

THE INSTITUTIONAL DYNAMICS OF HEALTH CARE REFORM:
ORGANIZATIONAL AND CLASS DIMENSIONS OF POLICY-MAKING AT THE
COLUMBIA-PRESBYTERIAN MEDICAL CENTER, 1911-1998

A Dissertation

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by

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Following the lead of Theda Skocpol, Jacob Hacker and other neo-institutionalists, this dissertation draws attention to the private and voluntary components of America's mixed systems of social insurance and health care provision. What distinguishes my approach is a closer view of institutional politics and policies, as well as an emphasis on their reciprocal connections with the larger political process. Drawing on the extensive administrative archives of the nation's oldest medical center, Columbia-Presbyterian Medical Center in New York, I reconstruct and analyze some of the formative moments of the American health care system. Two broad conclusions concerning American health care politics emerge from my analysis. First, academic medical centers, as well as private health care institutions more generally, make policies and shape health care politics. Thus, private institutions are policy-makers, in a very real sense. Second, private institutions of health care provision have participated in the making of health care policy not as monolithic, autonomous institutions but as internally contested and externally invested organizations. On the basis of my research, I propose a new theoretical framework which brings into view the organizational and social dimensions of health care politics that have been previously overlooked. The framework builds on two theoretical approaches – the neo-Durkheimian theory of micro-classes and the theory of intersectionality – to reveal a coherent set of political subjects and structures involved in health care politics. Central to this framework is a concept of 'institutional class positions,' which

links the mechanisms of bureaucratic power and occupational control with the effects of gendered and racialized systems of inequality to produce an integrated, dynamic understanding of institutional processes. I show that the organizational and social structures which shape these positions have far-reaching political effects, indicating the limits and possibilities of health care reform in the predominantly private framework of health care provision.

BIOGRAPHICAL SKETCH

Olena Mykolayivna Prokopovych was born and raised in Chernihiv, Ukraine. She attended Chernihiv Secondary School No. 29 and graduated with a Gold Medal. She was among the first few students from the former Soviet Union to independently apply and matriculate to an American institution of higher education. Olena was admitted and offered full scholarship to attend six top-rated liberal arts colleges. She chose to attend Williams College where she majored in Political Science and Economics and graduated Cum Laude with Honors in Political Science. Her honors thesis in political theory was entitled *Game, Power, Pleasure in the Works of Michel Foucault*. For her graduate studies, Olena attended Cornell University where she studied political theory and American politics.

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I thank my parents, grandparents and all other members of my loud, outspoken, and deeply empathetic family for developing my fundamental abilities to think, feel, speak, and write. Bravely and selflessly, my mother set me upon the journey across languages, cultures, and borders. From my father I have inherited priceless gifts of musicality, intellectual curiosity combined with modesty, and generous respect for traditions, large and small. My late maternal grandmother will always be my strongest link to my family, my homeland, history, and the past. I am deeply grateful to my aunts, uncles, cousins, step-father, beloved late grandparents, and god-parents for making our small family seem large.

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Above all, I thank my husband, David M. Tang, for being there for me every step of the way and for bringing the very best into my life. Pastry chef extraordinaire, knowledgeable music guide, fantastic entertainment manager, successful lawyer, and simply the sweetest, most loving partner, he made it possible for me to endure this trial.

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CHAPTER 1

INTRODUCTION

General Problematic

For most of its history, the American health care system has been dominated by private rather than public actors and by professional, rather than political ideologies, whereas American political science has focused on their opposites. During the first seven decades of the twentieth century, when American political science was quite at home in the study of the private social interests, its practitioners were nonetheless entranced by the general view that the realm of medicine and health care was characterized by professional considerations, rather than politics. After the veil of professional neutrality has been lifted, political science has abandoned the private sphere in favor of a near exclusive focus on the institutions of the state. Although shedding much needed light on newly expanded government involvement in health care, the discipline still ignores the proverbial elephant in the room – the private institutions and structures of health care provision.

Recent political developments – such as the Clinton administration’s campaign to create a national health insurance program, as well as George W. Bush’s effort to privatize Social Security – have contributed to a growing awareness of the analytical blind spot created by the exclusive focus on public institutions and programs. A crucial question at the center of these developments is the type and extent of social protection that should be publicly provided. Although this basic political question is not really new, political science has only recently begun to change its focus and concepts in a way that captures the centrality of the public/private split. For decades, students of welfare concentrated almost exclusively on the public programs of social provision and the public institutions which delivered them. All the while, private

institutions and instruments of social provision were left in the shade. In fact, the very concept of the ‘welfare state’ captures this bias in favor of public institutions and programs of social provision.¹

Nevertheless, during the past two decades there has emerged a growing literature challenging the exclusive focus on public welfare programs. In the mid-1980s, a study by Beth Stevens and a volume edited by Martin Rein and Lee Rainwater broached the topic of the mixed public/private regime of welfare provision.² The new conceptual turn was soon buttressed by several authoritative analyses of comparative welfare regimes.³ In 1997, Christopher Howard contributed a brilliant study, entitled *The Hidden Welfare State*, which examined an extensive array of tax mechanisms which create a network of welfare for a host of unexpected recipients, from home-owners to business firms. In 2001, Marie Gottschalk published *The Shadow Welfare State*, addressing the general problematic from a somewhat different direction – to investigate the role of business and labor unions in the shaping of the American system of health insurance. A year after that, Jacob Hacker came out with a very successful reaffirmation of this new trend, under the title of *The Divided*

¹ A few years ago, in fact, I came across an attempt to coin a related concept of the ‘health care state.’ [Michael Moran, *Governing the Health Care State: A Comparative Study of the United Kingdom, the United States and Germany* (Manchester: Manchester University Press, 1999)]. This, in my view, was not a helpful move, at least for the analysis of the American health care system, which gives a very large role to non-state actors.

² Beth Stevens, *Complementing the Welfare State: The Development of Private Pension, Health Insurance and Other Employee Benefits in The United States* (Geneva: International Labor Office, 1986); Martin Rein and Lee Rainwater, eds., *Public/Private Interplay in Social Protection: A Comparative Study* (Armonk, N.Y.: M. E. Sharpe, 1986).

³ Gøsta Esping-Andersen, *The Three Worlds of Welfare Capitalism* (Princeton, N.J.: Princeton University Press, 1990); Sven Steinmo, *Taxation & Democracy: Swedish, British, and American Approaches to Financing the Modern State* (New Haven: Yale University Press, 1993); Michael Katz and Christoph Sachsse, eds., *The Mixed Economy of Social Welfare: Public/Private Relations in England, Germany and the US, 1870s-1930s*, (Baden-Baden: Nomos, 1996).

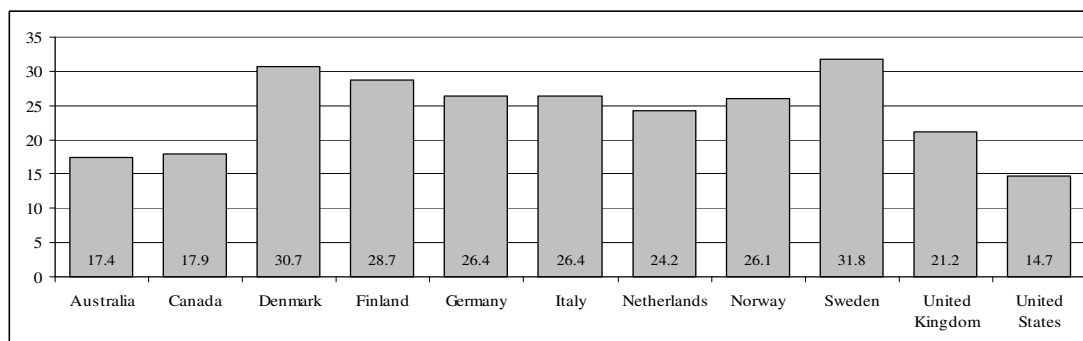
Welfare State, in which he provides a comparative view of the public/private divide in retirement security and health care insurance.⁴

The central argument proposed by this stream of scholarship is that an exclusive focus on the public programs of social provision is both incomplete and misleading. It is incomplete because it ignores the fact that a very sizable portion of social provision, upon which American citizens rely, is provided by private institutions and programs. It is misleading because it does not take into account that the political fate of public social provision is inextricably linked to these institutions and programs of private social provision, and vice versa.

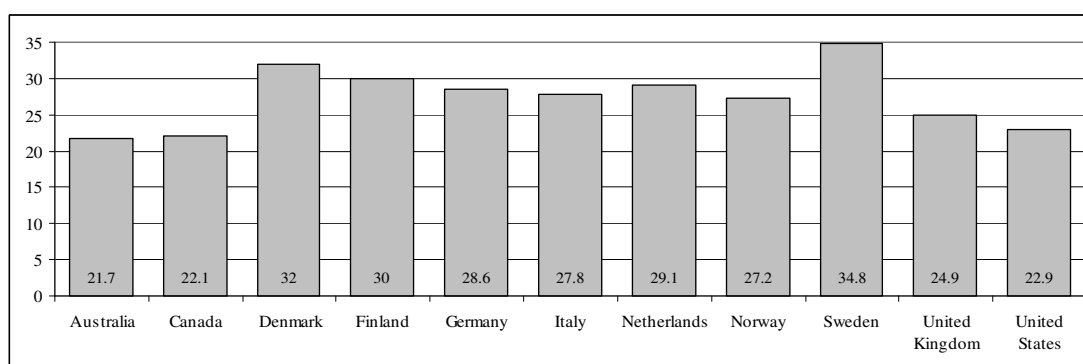
Even the most cursory look at social spending data gives a good idea of why it is so important to examine both public and private sides of social provision, particularly in studying the United States. The top chart in Figure 1.1 gives a comparison of public welfare spending as a percent of GDP across twelve developed nations. We notice that the United States significantly lags its counterparts in Europe, North America and Australia. If we compare total – both public and private – spending on social welfare, we see that the United States is one of a group of states, along with Australia, Canada and United Kingdom, which have liberal welfare regimes. Looking at the bottom chart, we see that the crucial distinction between the United States and the rest of the group is the portion of social spending which is provided by the private sector. In 1997, 36% of total social spending originated in the private sector and this proportion has probably increased in recent years. Even

⁴ Other notable works in this vein were: Neil Gilbert and Barbara Gilbert, *The Enabling State: Modern Welfare Capitalism in America* (Oxford: Oxford University Press, 1989); Steven A. Sass, *The Promise of Private Pensions: The First Hundred Years* (Cambridge, Mass.: Harvard University Press, 1998); Theodore R. Marmor, Jerry L. Mashaw, and Philip L. Harvey, *America's Misunderstood Welfare State: Persistent Myths, Enduring Realities* (New York: Basic Books, 1990); Michael Katz, *The Price of Citizenship: Redefining the American Welfare State* (New York: Henry Holt, 2001).

Public Social Welfare Spending as Percentage of GDP in Selected Countries



Total Social Welfare Spending as Percentage of GDP in Selected Countries



Public and Private Shares of Social Welfare Spending in Selected Countries

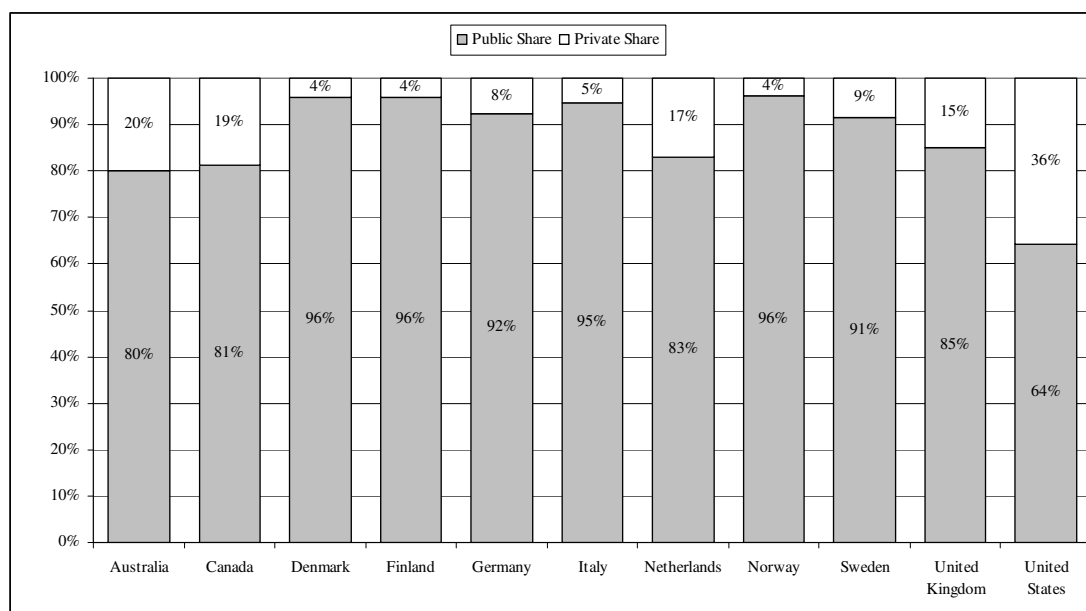


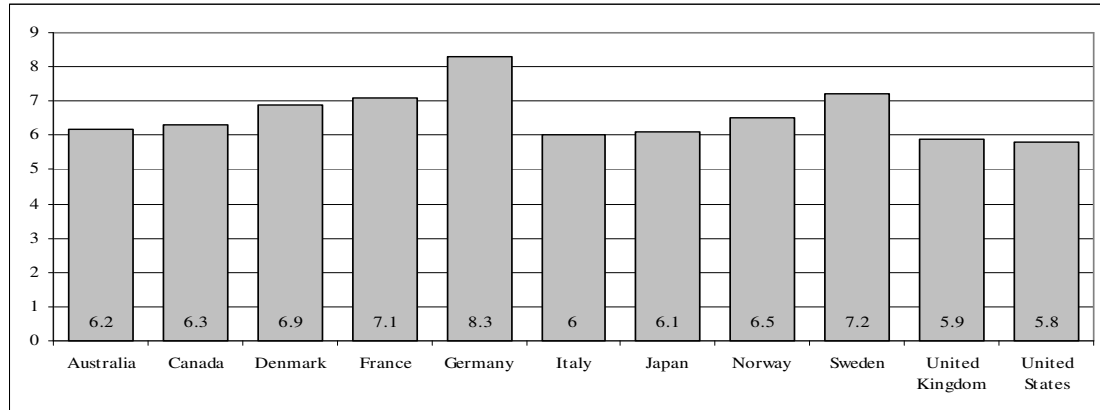
Figure 1.1. Comparative Levels and Sources of Welfare Spending, 1997. *Source:* Calculated from Willem Adema, “Net Social Expenditure,” 2nd Edition, *Labour Market and Social Policy – Occasional Papers No. 52* (Paris: OECD, 2001), p. 13.

compared to other heavy private spenders – like Canada and Australia – the United States looks markedly different.

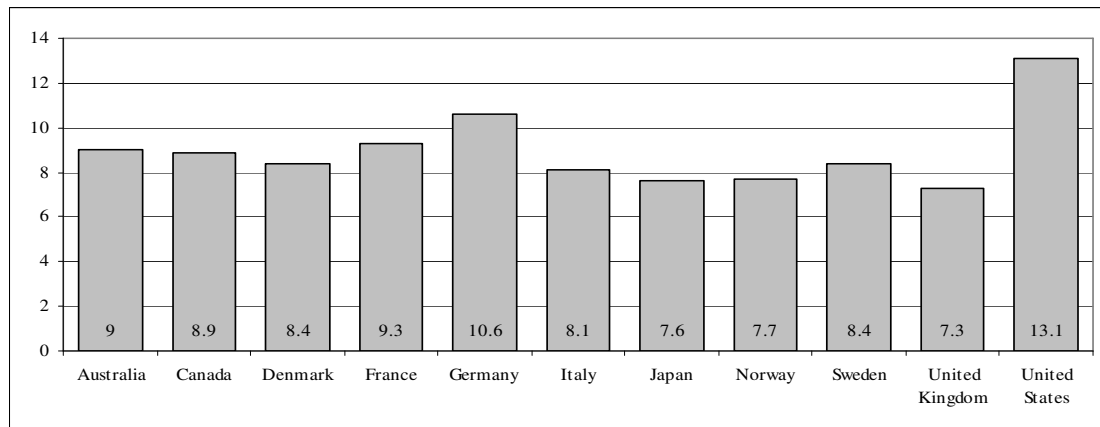
Looking at health care expenditures only in Figure 1.2, we can see once again how important it is to look at both public and private social provision. In terms of public expenditure alone, the United States seems to be spending almost as much as Italy, Japan, Australia, and Canada. This is actually somewhat surprising given that the United States, unlike these other nations, does not possess a universal public health care system. In terms of total spending, the picture is even more interesting since America comes out a clear leader. This certainly helps explain why the United States is the world leader in medicine and medical technology, although not why such heavy expenditure fails to secure health care benefits for all groups in society, comparable to more equitable delivery in other nations. Again, the most revealing picture emerges when we look at the relative shares of public and private health care spending. Here too, the United States has no peers. More health care spending is financed privately than publicly.

For most of American history, medicine and health care have been predominantly provided by households, private medical practitioners, and voluntary hospitals, with local and state governments maintaining supplemental institutions for the most destitute and least desirable patients. In the early twentieth century, American medicine has been reorganized around academic medical centers by a largely private coalition of corporate philanthropists and professional elites, while public health care has been tightly circumscribed within a limited sphere of influence. By the end of World War II, the drive for public health insurance has been largely deflected by the rapid spread of voluntary, employment-based coverage. Despite enormous and rapidly growing commitments of public resources to biomedical research, hospital construction, and other health care needs after WWII, the direct

Public Health Care Spending as Percentage of GDP in Selected Countries



Total Health Care Spending as Percentage of GDP in Selected Countries



Public and Private Shares of Health Care Spending in Selected Countries

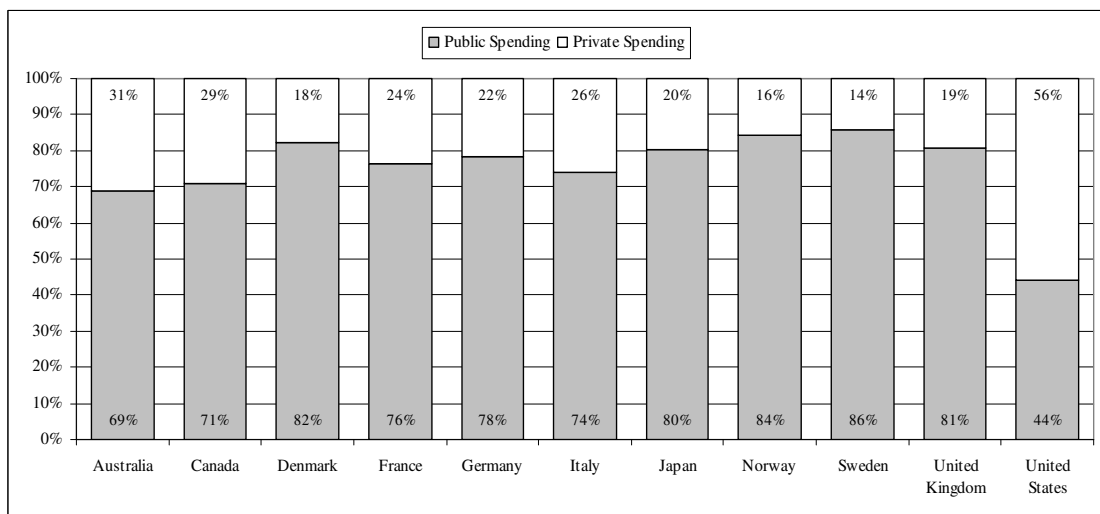


Figure 1.2. Comparative Levels and Sources of Welfare Spending, 2000. *Source:* Calculated from OECD Health Data 2004, 1st Edition (Paris: OECD, 2004).

public role in health care peaked with the creation of Medicare and Medicaid programs in the 1960s.

At the beginning of the twenty-first century, most Americans remain covered by private, employment-based insurance, most health care production remains in the hands of private institutions and businesses, and the number of people un- and under-insured is growing. In sum, the United States has not succeeded in enlarging the sphere of public interest within the health care sector since the 1960s. It is thus not surprising that the history of health care policy can be read as one of repeated failure to extend coverage to the most vulnerable. In fact, most recent trends point toward reprivatization and even recommercialization of medicine and health care. On the private side, however, there has been no lack of creative innovation in which most health care policy has been laid down in and by the private sphere. The predominantly private character of American health care system helps explain why, with few notable exceptions, the study of health care has been relegated to disciplines – sociology, history, etc. – more comfortable with studying power relations outside of the public sphere.

Political scientists nevertheless ignore the private side of health care politics at their own peril because, according to their own prevailing theories, we may be well be stuck with this predominantly private system for a long time to come. In addition to the sheer size of the private side of American health care system, there are several other reasons why it should be closely studied. First, American health care in the last three decades has been characterized by a notable movement toward recommercialization and a deeper privatization of institutional structures and services. Second, this movement has coincided with a ‘conservative resurgence’ in the American political arena and ‘the turn against government’ in the broader cultural

sphere.⁵ Lastly, the ensemble of private health care institutions which have flourished in this country are the product of classic processes of path dependence, policy feedback, and critical juncture and are thus theoretically quite interesting. All three characteristics have been articulated in recent political science scholarship.

Figure 1.3 classifies the scholarship on social provision in accordance with two criteria: (1) whether its primary focus is on public or private sphere of welfare provision and (2) whether it primarily studies welfare programs and policies or institutions that formulate and carry out these programs and policies. In political science, most of the research is concentrated on the public sphere (the darker shaded areas) with a small but growing minority of studies concerned with policies and programs in the private sphere (the lighter shaded area).

		<i>Sphere of Welfare Provision</i>	
		Public Sphere	Private Sphere
<i>Institutions/ Policies Distinction</i>	Welfare Functions (Policies & Programs)		
	Institutions Formulating and Carrying Out Welfare Functions		

Figure 1.3. Neglected Field of Political Science Scholarship on Welfare Provision.

⁵ Theda Skocpol, *Boomerang: Health Care Reform and the Turn Against Government* (New York: W.W. Norton: 1996).

Few if any studies are centrally concerned with private institutions involved in welfare provision (the unshaded area in Figure 1.3). Studies with this focus are predominantly conducted by the scholars in other social science disciplines, notably history and sociology. While exploring the roots of this ‘division of labor’ is beyond the scope of this investigation, its consequences can be easily envisaged. Bracketing off private institutions is a source of bias. Private institutions – in the economy and in the civil society – are important and enduring parts of the American polity, no less important than the institutions of government. It is the polity – in this broader definition – and not simply government which is a proper subject of analysis for political science. Neglecting to study private institutions involved in any type of political processes excludes distinctive actors, systems, and dynamics imminent in the private sphere that are important contributors to public policy decisions. Among these are legal frameworks, economic realities, and cultural practices that are fundamentally determinative in our social world.⁶

When political scientists have turned their (albeit limited) attention to private health care institutions, they have failed to deeply explore the elaboration and change in the policy positions of these institutions, to note dissent and conflict within their ranks beyond the most basic structural cleavages, and to report efforts to ‘engage’ these institutions or their subgroups in policy dialogue.⁷ Even though observers have frequently attested to the head-spinning pace of structural change in the arena of health care politics, in the final analysis, few scholars evinced real interest in the positions of these private players. As Theda Skocpol puzzlingly admitted in her fascinating

⁶ This set of assumptions is generally shared by the field of political economy. See, for example, James A. Caporaso and David P. Levine, *Theories of Political Economy* (Cambridge: Cambridge University Press, 1992).

⁷ See, for example, Jacob Hacker’s treatment of private health care interests in *The Divided Health Care State*, Chapter 5.

account of the Clinton administration's attempt at health care reform, "[a]s [she saw] it, people mostly acted as one would expect, given their institutional locations, the political resources they had at their disposal (or not), and their ideas as one can see them in contemporaneous writings."⁸ In general, the interests and politics of private health care institutions are more assumed than studied and few scholars have deeply analyzed the positions and actions these institutions have taken in particular political struggles. In fact, however, we should be surprised with respect to the positions taken by the private sector actors in the most recent attempt at national insurance. And we should certainly be amazed at the endogenous developments in the private health care sector in the past two decades. And we would be, had we studied them.

Dissatisfaction with prior studies of private health care politics led me to focus my project on clarifying the structures and dynamics of politics and policy-making within private medical institutions. An extended list of scholarship – drawn from several disciplines of social science – has helped me generate a useful list of suppositions, hypotheses, and analytical frameworks with which to approach an otherwise seemingly random stream of archival data. Paul Starr's and Kenneth Ludmerer's magisterial histories of American medicine and medical education are indispensable starting points for any research concerned with medicine and health care.⁹ In history, the works of Richard Brown, George Rosen, Charles Rosenberg and Rosemary Stevens have been tremendously helpful in suggesting a multi-faceted,

⁸ Theda Skocpol, *Boomerang: Health Care Reform and the Turn Against Government* (New York, London: W.W. Norton & Company, 1997), p. xiii.

⁹ Paul Starr, *The Social Transformation of American Medicine: The Rise of A Sovereign Profession and The Making of A Vast Industry* (New York: Basic Books, 1982); Kenneth M. Ludmerer, *Learning to Heal: The Development of American Medical Education* (New York: Basic Books, 1985) and *Time to Heal: American Medical Education from the Turn of the Century to the Era of Managed Care* (Oxford: Oxford University Press, 1999).

institutionally-grounded approach to stratification in health care settings.¹⁰ In sociology, the brilliant early study by Magali Sarfatti Larson served as an inspiring example of applying classical approaches to the problems of modern professional organizations.¹¹ In political science, the works by Theodore Marmor, Theda Skocpol, Jacob Hacker, Lawrence Jacobs, James Morone, and Jill Quadagno provided much needed reassurance that health care politics is growing as a subject of our discipline's attention.¹² A host of excellent works focused on the large issues of public health provided invaluable reminders of what is at stake.¹³

¹⁰ Richard Brown, *Rockefeller Medicine Men: Medicine and Capitalism in America* (Berkeley and Los Angeles: University of California Press, 1979); George Rosen, *The Structure of American Medical Practice, 1875-1941* (Philadelphia: University of Pennsylvania Press, 1983); Charles E. Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (New York: Basic Books, 1987); Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century* (Baltimore, MD: The Johns Hopkins University Press, 1989).

¹¹ Magali Sarfatti Larson, *The Rise of Professionalism: A Sociological Analysis* (Berkeley: University of California Press, 1977).

¹² Theodore Marmor, *The Politics of Medicare*, 2nd ed. (Aldine de Gruyter, 2000), *Understanding Health Care Reform* (Yale University Press, 1994) and *Political Analysis and American Medical Care: Essays* (Cambridge University Press, 1983); Theda Skocpol, *Boomerang: Clinton's Health Security Effort and the Turn Against Government in U.S. Politics* (New York: W.W. Norton, 1996); Jacob S. Hacker, *The Road to Nowhere: The Genesis of President Clinton's Plan for Health Security* (Princeton University Press, 1997), "Dismantling the Health Care State? Political Institutions, Public Policies, and the Comparative Politics of Health Reform," *British Journal of Political Science* 34 (October 2004): 693-724; James A. Morone and Lawrence R. Jacobs, eds., *Healthy, Wealthy, & Fair: Health Care and the Good Society* (New York: Oxford University Press, 2005); Lawrence R. Jacobs, *The Health of Nations: Public Opinion and the Making of American and British Health Policy* (Ithaca, NY: Cornell University Press, 1993); Jill Quadagno, *One Nation, Uninsured: Why the U.S. Has No National Health Insurance* (Oxford University Press, 2005).

¹³ Vicente Navarro, *The Political Economy of Social Inequalities: Consequences for Health and Quality of Life* (Amityville, NY: Baywood, 2002); Howard D. Waitzkin, *The Second Sickness: Contradictions of Capitalist Health Care* (New York: Free Press, 1983); Harry F. Downing, *City Hospitals: The Undercare of the Underprivileged* (Cambridge, Mass.: Harvard University Press, 1977); D. Coburn, "Income Inequality, Social Cohesion and the Health Status of Populations: the Role of Neoliberalism," *Social Science and Medicine* 51 (2000), pp. 135-146; H. Graham, "Building an Inter-Disciplinary Science of Health Inequalities: The Example of Life Course Research," *Social Science and Medicine* 55 (2002) pp. 2005-2016; M. Marmot, "Social Inequalities in Mortality" in *Class and Health: Research and Longitudinal Data*, ed. R. G. Wilkinson (London: Tavistock, 1986); G. Pappas, S. Queen, W. Hadden, G. Fisher, "The Increasing Disparity in Mortality Between Socioeconomic Groups in the United States, 1960 and 1986," *New England Journal of Medicine* 329 (1993), pp. 103-109; J. Hadley, *Sicker and Poorer: Health Insurance, Health, and the Consequences for Work, Income, and Education of a Large Uninsured Population* (Washington, D.C.: Kaiser Commission on Medicaid and Uninsured, 2002).

Aiming at micro- and meso-levels of the political struggle I chose to undertake a historical-interpretive case study of one of the oldest and largest medical centers in the nation.

Topic and Question

This dissertation is concerned with a category of health care institutions which political scientists have overlooked both as a class and a genus: private and voluntary institutions of health care provision. Although those who have become aware of the singular extent and importance of our private welfare system have repeatedly called for closer study of these institutions, the response has been rather tepid. My own approach harks back to the classical definition of politics proposed by Harold Lasswell as “who gets what, when, and how,” a definition which emerged before decades of narrowing focus on the formal political sphere and which is singularly fitting in government-weary American society. By this definition, private and voluntary institutions have played a tremendously important and unmistakably political role in the shaping of our health care system. From the powerful medical profession to university medical centers, from Blue Cross to HMOs, private institutions and programs have been the most extensive and dynamic elements of our health care system. Their impact and consequences have been tremendous, defining the character of health care services, products, and programs for most Americans up to and including this very day.

This study focuses on the category of mostly private institutions which have been practically and symbolically central to modern American health care: academic medical centers. Academic medical centers (AMCs) is a typical name born by those institutions uniting university-affiliated medical schools with teaching hospitals. As an institutional form, academic medical centers emerged during the early decades of

the twentieth-century and have been practically synonymous with modern American medicine. In the words of historian Kenneth Ludmerer,

No factor has been more important to the achievements of medical practice in the United States than the country's medical schools and teaching hospitals (or academic health centers, as the joint institutions are typically called.) Their importance lay in the education of the nation's doctors, generation of new medical knowledge, introduction and evaluation of innovative clinical practices, and provision of the most sophisticated medical care available.¹⁴

From the perspective of political science, these institutions may well be even more important than Ludmerer believes. Earlier in the twentieth century, academic medical centers were at the center of the struggle to define the ways in which modern American medicine would be funded and organized.¹⁵ After the Second World War, these institutions became the main parties of the so-called science contract which marked the emergence of government as the main financing source of biomedical research.¹⁶ Throughout the past century, medical centers have been among the 'main engines' in the transformation of institutional organization of labor in medicine and health care. During the 1960s and 70s, these institutions were the epicenters of struggles to unionize health care workers and efforts to solve the urban health care crisis. At the dawn of the twenty-first century, academic medical centers are the weary survivors of the new stringency in both public and private financing and

¹⁴ Kenneth M. Ludmerer, *Time to Heal: American Medical Education from the Turn of the Century to the Era of Managed Care* (Oxford: Oxford University Press, 1999), p. xix.

¹⁵ Richard Brown, *Rockefeller Medicine Men: Medicine and Capitalism in America* (Berkeley and Los Angeles: University of California Press, 1979).

¹⁶ Bruce L.R. Smith, *American Science Policy Since World War II* (Brookings Institution Press, 1990); David H. Guston, *The Fragile Contract: University Science and the Federal Government* (Boston: The MIT Press, 1994).

perhaps, as some fear, (albeit half-hearted) participants in medicine's recommercialization.¹⁷

Historical and sociological studies of academic medical centers and related institutions suggest that these organizations have been home to a variety of both progressive and conservative agendas and of varying orientations toward pro-active and collective management of health care economy. Yet existing explanations of the structure and dynamics of their politics inadequately account for the degree of diversity and conflict within them. For example, a long-standing analytical perspective emphasizing professional sovereignty has lost its tremendous force in light of the spectacular reversals of fortune in the organizational cohesion and political power of the medical profession and provider institutions in the face of the managed care revolution. Previous narratives of the rise and decline of the medical centers' public character also strained credulity with respect to their benevolence. Studies emphasizing the uniqueness of the voluntary non-profit form have not examined the durability of this quality in the face of the overall shift toward more corporate and market-based approaches.

Method and Cases

The historical part of my investigation employs a case study method. Used in many classic and contemporary studies in political science, this method has recently received systematic methodological clarification which allows us to specify more rigorously some features of this research design.¹⁸ Following John Gerring, I define

¹⁷ Ludmerer, *Time to Heal*; Henry J. Aaron, *The Future of Academic Medical Centers* (Brookings Institution Press, 2001); Sheldon Krimsky, *Science in the Private Interest: Has the Lure of Profits Corrupted Biomedical Research?* (Rowman & Littlefield, 2003).

¹⁸ The following are a few classical works in political science employing the case study method: Robert A. Dahl, *Who Governs?: Democracy and Power in an American City* (New Haven, CT: Yale University Press, 1961); William Sheridan Allen, *The Nazi Seizure of Power: The Experience of a Single German Town, 1930-1935* (New York: Watts, 1965); Graham T. Allison, *Essence of Decision: Explaining the Cuban Missile Crisis* (Boston: Little, Brown, 1971); Jeffrey L. Pressman and Aaron

case study as an intensive investigation of a single unit for the purpose of understanding a larger class of similar units.¹⁹ Contrary to common misconception, a case study is not an instance of an $N=1$ research design because such design constitutes a logical impossibility. No logical inferences whatsoever can be drawn from an observation of a single phenomenon at a single point in time. At the very least, case studies observe a single phenomenon over time. More commonly, a case study uses one of three research designs: (1) examining variation in a single unit over time; (2) breaking down the primary unit into subunits and subjecting them to synchronic covariational analysis [synchronic within-unit variance] or (3) studying subunits both synchronically in time and across time [synchronic and diachronic within-unit variance].²⁰

The most common variety of case study analysis – a combination of temporal and within-unit variation – is a research design employed in my dissertation. This type of investigation involves a change in level of analysis – as cases are drawn from phenomena within the primary unit – and thus requires some clarification. The primary unit of my analysis is the Columbia-Presbyterian Medical Center (CPMC). The study of this single unit is undertaken with the view to understanding a broader class of units, i.e. all American private medical centers.²¹ The research design

Wildavsky, *Implementation* (Berkeley: University of California Press, 1973); Theodore R. Marmor, *The Politics of Medicare* (Chicago: Aldine, 1973).

¹⁹ John Gerring, “What is a Case Study and What Is It Good for?” *American Political Science Review*, Vol. 98, No. 2, May 2004, 341-354.

²⁰ Gerring, pp. 342-346. Gerring’s analysis elaborates on a theme first articulated and developed by Campbell. [Donald T. Campbell, “‘Degrees of Freedom’ and the Case Study” in *Methodology and Epistemology for Social Science*, ed. E. Samuel Overman (Chicago: University of Chicago Press, 1975/1988); Donald T. Campbell and Julian Stanley, *Experimental and Quasi-Experimental Designs for Research* (Boston: Houghton Mifflin, 1963).]

²¹ As Gerring points out, one of the intrinsic ambiguities of case studies concerns the analytical field to which its findings may be legitimately applied. Case studies are both *studies* of very specific phenomena and *case* studies of something more general. As a study, the population is restricted to the unit under investigation. As a case study, the population includes adjacent units. Thus, a clear delineation of one’s claims and a justification for extending the findings from a study of one case to a broader category of phenomena are very important.

involves “observation” and comparison of five within-unit cases, defined as historical instances of intense political struggle in which the CPMC was centrally involved, and compares them with each other.²² Furthermore, each of the five cases consists of multiple observations of the configuration and dynamic of the political struggle as it unfolded over time.

As is often the case, my choice of case was dictated by reasons both scholarly and personal. In retrospect, the choice of Columbia-Presbyterian Medical Center could not have been more fortuitous. The first institution of its kind in the nation, CPMC was centrally involved in some of the crucial struggles which shaped American academic medicine and its institutional policies have influenced the entire field of its sister institutions. The Center’s location amidst America’s premier metropolis has placed it at the forefront of dealing with a host of decisive social crises of the past century, including immigration, discrimination, growing economic inequality and urban decay. From amid the many interesting instances of institutional politics and policy-making, I chose five broadly relevant struggles, drawn from different periods of the Center’s history and bearing on different aspects of institutional structure.

My first case, the subject of Chapter 3, focuses on one of the foundational moments in modern American medicine. At issue was whether all of the medical school faculty – including those in clinical departments – should be required to hold ‘full-time’ appointments, i.e. to forego all private practice and to devote all their time to research, teaching, and professional services in the teaching hospitals. Although nominally confined to medical schools and their affiliated hospitals, the issue had profound consequences for the overall organization of health care provision in America. One of the pivotal episodes in the struggle over the ‘full-time’ requirement

²² The five cases correspond to the five historical chapters (Chapters 3-7) and the cases of political struggle they investigate.

took place at Columbia-Presbyterian between 1910 and 1925 and nearly derailed the building of the nation's first Medical Center. The outcome of this conflict was path-setting in at least two ways. First, it set the policy for the entire field of academic medicine in the United States and, secondly, it had enormous implications for the course of future development of American medical centers and medicine as a whole.

My second case, presented in Chapter 4, focuses on construction of the Medical Center and the first two decades of its institutional development. Two of the most visible conflicts and compromises of the construction process concerned the outpatient department and the hospital accommodations for the so-called 'semi-private' patients. Their outcomes underscored how deeply the professional and organizational structure of academic medicine was implicated in the creation of differentiated patient services. During the first two decades of its existence, the Center added several specialized hospitals to its site, while affiliating with a dozen other regional institutions. Its relationship with public institutions was especially noteworthy, reflecting both familiar and changing division of labor in American medicine. The pattern of institutional structure and relationships which emerged during this period was deeply informed by class, race and other salient social divisions among patients, as well as occupational and organizational hierarchies within the medical profession.

My third case, presented in Chapter 5, reconstructs nearly a century of debates and developments surrounding the admission of women, racial minorities and members of ethno-religious and immigrant groups, viewed in the broader context of the Center's employment structure and semi-professional training. Analyzing the function of educating and employing physicians in terms of the reproduction of a particular segment of the professional middle class, I show that academic medical centers played an active role in constructing a class system that was simultaneously

divided by gender, race, and ethno-religious identity. Comparing and contrasting the substantially different methods of discrimination practiced against women, African-Americans, and Jewish and Catholic applicants, I emphasize both comprehensive and complex structures of inequality, in which exclusion is imposed by different institutions with regard to different groups. Even when nominally included, the marginalized groups are relegated to the ‘class of their own.’

Chapter 6 presents my fourth case of institutional politics and policymaking. During the 1960s and early 1970s, New York City was the epicenter of a drive to unionize non-professional health care workers, a political struggle with far-reaching consequences for the nonprofit sector as a whole. Although the conflict prompted a series of governmental interventions, the crucial battles took place at the level of individual institutions and their organized opponents. As a result, the structure and politics of particular institutions played a significant role in shaping the course and outcome of the struggle. Divergent dynamics involved in the unionization of non-professional and semi-professional workers have been frequently noted in the analysis of this period, yet the differences *within* these groups were just as salient as those between them. Some factors, which are usually considered unitary, had different and even contradictory effects in different contexts. Gender, for instance, was one such multi-dimensional factor in the unionization struggle at Columbia-Presbyterian. Cleavages between the participants were not prefigured in the organizational and social structure of the Center, but were constructed in the process of struggle by the rhetorical and practical strategies of the rival organizations.

My final case, presented in Chapter 7, focuses on the period between the early 1960s and the mid-1970s, during which a cluster of issues under the rubric of ‘community health planning’ dominated both public policy and private efforts to solve a health care crisis in the lower-class, minority neighborhoods. Like the larger

movement, Columbia's community health planning initiative was both short-lived and largely unsuccessful, even on its own terms. I show that the fragmented, hierarchical, and insular structure of the Medical Center was largely responsible for the initiative's failure. Although limited and ultimately unsuccessful, the initiative's engagement with community organizations and other hospitals, as well as its attempt at internal cross-departmental cooperation, point toward those factors which might potentially augment reflexive, socially-conscious institution-building.

In all five cases, the issues involved in the Columbia-Presbyterian case also shaped policy and politics in many other medical centers and other health care institutions. The origins and overall outcomes of these struggles are largely consistent with other broadly accepted historical accounts but the novel understanding of interests and divisions suggested by my work offers a new interpretation of their structural dynamics and political significance.

Research Sources

The primary research sources for my dissertation are held in the Archives and Special Collections of the Health Sciences Division of the Columbia University located in the Augustus C. Long Health Sciences Library, Columbia University, 701 W. 168th Street, New York, NY. As currently constituted, the Archives serve as the repository for the institutional records of Columbia University's Health Sciences Division that are permanently retained because of their historical, legal, or evidential value. The repository contains approximately 1,000 cubic feet of archival records spanning the period from 1791 to the present. Although the collection includes materials from all four health science schools, records from the College of Physicians and Surgeons, Columbia University's medical school, predominate. While the repository does not serve as an official archive for Presbyterian Hospital (1868-1997, now part of New York-Presbyterian Hospital), the collection includes many

documents relating to that institution because of the close relationship between Columbia and Presbyterian, beginning with the creation of the Columbia-Presbyterian Medical Center in 1911. The largest group of records, and the one most important for my research, comes from the Office of the Vice President for Health Sciences, containing 598 cubic feet of material and dating from the 1880s into the late 20th century. Because the Office has oversight over all health sciences education at Columbia, its records are unusually comprehensive, documenting a wide range of issues pertaining to all health science schools, centers and institutes, as well as their clinical affiliates. Most records are closed to outside researchers for twenty-five years, while a small portion of documents – notably the minutes of the Board – are sealed for seventy-five years.

Several books pertaining to the history of Columbia-Presbyterian Medical Center and its member institutions were indispensably useful. A volume written by the long-time member of the clinical staff, Dr. Albert R. Lamb, *The Presbyterian Hospital and the Columbia-Presbyterian Medical Center, 1868-1943* (New York: Columbia University Press, 1955) still remains the most comprehensive history of the institution. An institutional monograph written by the long-time Dean of the medical school helped reconstruct the institution's history through the late 1950s.²³ Harold Speert's *The Sloane Hospital Chronicle: A History of the Department of Obstetrics and Gynecology of the Columbia-Presbyterian Medical Center* (Philadelphia: F.A. Davis Company, 1963) usefully recounts the early history of Columbia Medical School. Two early histories of Columbia-Presbyterian's Schools of Nursing authored by its third director, Ms. Eleanor Lee, are essential sources on nursing education and hospital nursing, while a more recent history commissioned for the centennial of the

²³ Willard C. Rappleye, *The Current Era of the Faculty of Medicine, Columbia University, 1910-1958* (New York, Columbia University, 1958).

school and written by an outside author, Gary Goldberger, added a welcome critical perspective.²⁴ Horace Coon's *Columbia: Colossus on the Hudson* – a mid-century history of the University as a whole – provided a synoptic view of some of the broad institutional developments, including the politics of women's admission to the various divisions of the University.²⁵ A personal memoir by Nicholas Murray Butler, one of Columbia University's most influential leaders, covers similar ground.²⁶ General histories of American medicine and medical education which have informed my broader understanding and helped me formulate specific research problems are too numerous to mention here but are referenced where appropriate in my footnotes.

Theoretical Framework

While calls for greater attention to the private institutions of social provision have been made, the recent political science literature has not, by and large, delved very deeply into the structure and dynamics of politics that take place within these institutions. More significantly, analytical tools for the study of these organizations remain inadequate, especially with respect to the structures of social division and conflict permeating their institutional spaces.

²⁴ Eleanor Lee, *History of the School of Nursing of the Presbyterian Hospital, New York, 1892-1942* (New York: G. P. Putnam's Sons, 1942); Eleanor Lee, *Neighbors 1892-1967: A History of the Department of Nursing, Faculty of Medicine, Columbia University, 1937-1967, and Its Predecessor the School of Nursing of the Presbyterian Hospital, New York, 1892-1942* (Columbia University-Presbyterian Hospital School of Nursing Alumnae Association, Inc., 1967); Gary Goldenberg, *Nurses of a Different Stripe: A History of the Columbia University School of Nursing, 1892-1992* (New York: Columbia University School of Nursing, 1992).

²⁵ Horace Coon, *Columbia: Colossus on the Hudson* (New York: E.P. Dutton & Company, 1947). This genre of the University's history writing has been recently updated in the recently volume by Robert McCaughey, *Stand, Columbia: A History of Columbia University* (Columbia University Press, 2003). Another welcome recent addition to Columbiana and one that focuses uniquely on the issue of gender is Rosalind Rosenberg's *Changing the Subject : How the Women of Columbia Shaped the Way We Think About Sex and Politics* (Columbia University Press, 2004).

²⁶ Nicholas Murray Butler, *Across the Busy Years: Recollections and Reflections* (New York: Charles Scribner's Sons, 1935). A recent biography provides a useful companion volume: Michael Rosenthal, *Nicholas Miraculous: The Amazing Career of the Redoubtable Dr. Nicholas Murray Butler* (Farrar, Straus and Giroux, 2006).

Both historical and sociological studies of American health care suggest that private, non-profit institutions of health care constitute elaborate systems of social division. At the very least, academic medical centers, which typically comprise university-affiliated schools of health sciences and their clinical affiliates, encapsulate the following fields of organizational complexity: (1) an unequal division of professional and academic work; (2) fragmented professional and non-professional hierarchies; (3) discriminatory admission to the study in health sciences and professions; (4) wide variation in access to health care services and patient care quality; and (5) mixed systems of professional, bureaucratic, elite, and community governance. These systems of institutionalized organizational division are thoroughly political, in that they determine who gets what, when, and how within the economies of health care constituted by academic medical centers. More importantly, these systems compose institutional frameworks, within which the processes of struggle and change unfold. Understanding both these structures and the struggles which they engender is a crucial task if we are to stay abreast of change within our privatized system of health care.

The historical part of my project involved constructing – from archival and secondary sources – five episodes of political struggle involving the structures of institutional organization outlined above. The theoretical aim of this undertaking was to elicit a common theoretical conceptualization of the processes which were involved in these struggles. My question was primarily one of conceptual ‘vision.’ What do I see? Who is acting? How are the lines of conflict being drawn? What differences and divisions are being constructed? One early conclusion was that the structure of politics in the academic medical centers was not adequately explained by existing theories. From the perspective of stratification theory (which emphasizes class, status, and ascriptive divisions), the groups which I saw acting were but fractions of primary

units, (i.e., class fractions, sub-groups within occupations, and groups emerging at the intersection of race, gender, class and other dimensions). From the point of view of the organizational analysis (which emphasizes bureaucratic and institutional categories of structuration), what I saw most often were the *socially* differentiated sub-groups of bureaucratic and occupational units, as well as groups and interests emerging at the intersection of institutional boundaries.²⁷

My focus on a single organizational unit is well suited to the generation of a broad theory because case studies enjoy a natural advantage in research of an exploratory nature.²⁸ In a typical fashion, my entry into this case study began with sifting through piles of seemingly random and unrelated data, the consideration of competing analytical perspectives, and even basic redefinition of the problem I faced. Yet, as Gerring so aptly puts it,

[i]t is the very fuzziness of case studies that grant them a strong advantage in research at exploratory stages, for the single-unit study allows one to test a multitude of hypotheses in a rough-and-ready way. The covariational relationships discovered among different elements of a single unit have a *prima facie* causal connection: they are all at the scene of the crime. This is revelatory when one is at an early stage of analysis, for there is no identifiable suspect and the crime itself may be difficult to discern.²⁹

It is for this reason that case studies are commonly understood as ‘heuristic studies’ and ‘theory-building’ exercises.³⁰ The painstaking single-case archival research

²⁷ For a convenient review of the numerous and diverse orientations in organizational theory, see, for example, Jay M. Shafritz, and J. Steven Ott, *Classics of Organization Theory* (Fort Worth: Harcourt Brace, 1996).

²⁸ The distinction between what Gerring terms the exploratory and confirmatory stages of the research process is an old one. [See, for instance, Karl Popper, *Conjectures and Refutations* (London: Routledge and Kegan Paul, 1969).] According to Gerring, “[p]ath-breaking research is, by definition, exploratory. Subsequent research on that topic is confirmationist insofar as its primary task is to verify or falsify a preexisting hypothesis or a set of hypotheses. ... These constitute two moments of empirical research, a generative moment and a skeptical moment, each of which is essential to the progress of a discipline.”

²⁹ Gerring, p. 350.

³⁰ *Ibid.* See, for example, Harry Eckstein, “Case Studies and Theory in Political Science” in *Regarding Politics: Essays on Political Theory, Stability, and Change* (Berkeley: University of California Press,

presented an ideal way to rethink the categories of difference which structure the intra-organizational struggles within the health care field.

The case study format is well fitted to the descriptive and categorizing inference which is a large part of the analytical work. In social sciences, descriptive propositions are held together by the logic imminent in our language, including both ordinary and technical terms, their definitions, and their relations to other terms. Language, in this sense, provides a method that allows for consistent interpretations of the phenomenal world. To describe is also to categorize, the latter involving either re-creating or modifying the linguistic devices with which we conceptualize the world.³¹

Both a realization of the need for a new theoretical framework and its articulation resulted from a close engagement with the particular facts of my case. My research leads me to conclude that the primary lines of conflict and contestation systematically combined the following five dimensions of intra-organizational division: (1) occupational [location within the occupational division of labor]; (2) organizational [both as organization membership and as location within organizations]; (3) social class; (4) gender; and (5) race, including racial, ethnic, and ethno-religious divisions. While these categories are not new, the social groupings which emerge at the intersection of these five divisions are only beginning to be recognized in the analytical vocabulary of social sciences.³²

1992 [1975]); Charles C. Ragin and Howard S. Becker, eds. *What Is a Case? Exploring the Foundations of Social Inquiry* (Cambridge: Cambridge University Press, 1992); Charles C. Ragin, "Turning the Tables: How Case-Oriented Research Challenges Variable-Oriented Research." *Comparative Social Research* 16 (1997): 27- 42; Alexander L. George and Andrew Bennett, *Case Studies and Theory Development in the Social Sciences* (Boston: MIT Press, 2005).

³¹ This discussion is adopted from Gerring who cites Giovanni Sartori, "Guidelines for Concept Analysis" in *Social Science Concepts: A Systematic Analysis* (Beverly Hills, CA: Sage, 1984), pp. 15-48 as a source on the functioning of language as 'laws' of interpretation.

³² While in political science, this deficiency stems from a systematic lack of interest in micro- and meso-levels of institutional politics, the field of organization theory offers little help in virtue of its abandonment of political concerns.

The conceptual framework developed in this dissertation builds on two theoretical approaches: the neo-Durkheimian theory of micro-classes and the theory of intersectionality.³³ Advanced by David Grusky and his collaborators, the neo-Durkheimian approach proceeds from the recognition that “scholars have over-invested in the search for aggregate classes and under-invested in the study of more deeply institutionalized groupings at the disaggregate level.”³⁴ It suggests that “class analysis should be ratcheted down to an analytic level where real social groupings (i.e. ‘occupations’) form.”³⁵ In general terms, the neo-Durkheimian approach requires that we disaggregate conventional ‘large-class’ categories and look instead for class-like effects at the micro-level of local organization. The main rationale for disaggregation is that “occupational categories are deeply embedded in the institutions of advanced industrialism, whereas aggregate classes are highly abstract constructs that have currency among academics more than workers, employers, or the state.”³⁶ More realistic analyses of contemporary societies require “new micro-class models that go beyond big-class nominalism and exploit such local social organization as can be found.”³⁷

While the neo-Durkheimian approach presents a powerful case for disaggregation and attention to local organizational structures, its singular focus on occupations and occupational associations is not unproblematic. Both particular occupations and the larger system of occupations are significantly structured and divided by multiple dimensions of difference, including race, gender, class, as well as

³³ For a detailed discussion of my theoretical framework, see Chapter 2.

³⁴ David B. Grusky in collaboration with Gabriela Galescu, “Foundations of a Neo-Durkheimian Class Analysis” in *Approaches to Class Analysis*, ed. Erik Olin Wright (Cambridge, UK: Cambridge University Press, 2005), p. 67.

³⁵ David B. Grusky and Kim A. Weeden, “Decomposition without Death: A Research Agenda for a New Class Analysis,” *Acta Sociologica* 44 (2001): 203-18, p. 203.

³⁶ *Ibid.*, p. 204.

³⁷ David B. Grusky with Gabriela Galescu, “Foundations of a Neo-Durkheimian Class Analysis,” p. 81.

by the organizational structures of industries, employment, and education. In my view, the better way to arrive at a disaggregated conception of social stratification is suggested by the theory of intersectionality. Its central contention is that social inequality, as well as the socially constructed divisions upon which it builds, should not be perceived as a monolithic construct with one overriding logic. Rather, they should be viewed as multidimensional and varied terrain constantly adapting to different contexts. This terrain is structured by race, class, gender, sexuality, nationality, religion and other systems of social division which condition the life chances within both the empowered and disempowered groups. Within this framework each hierarchical system is conceived as both partly autonomous and intersecting with others. Within this structure of complex inequality, the manner and degree to which each dimension of difference shapes concrete social positions is highly varied. Depending on historical, cultural, and institutional context, the intersecting systems may be organized and deployed in different ways and with different effects.

For the purpose of the present project – which is concerned with the institutional politics of the academic medical centers – five dimensions of inequality are of central importance. They are: (1) class, (2) gender, (3) race, (4) occupational divisions, and (5) organizational hierarchies. This is not an exhaustive list of differences structuring the many areas in the health care field but the minimal set of specifications necessary to understand the historical material investigated in this dissertation. My research shows that organizational politics were frequently articulated and structured in terms of divisions, interests, and strategies lying at the intersection of class, gender, racial, occupational and organizational dimensions of difference. While frequently contingent and malleable, groups and interests that emerged at these intersections were not only quite meaningful to the actors, but also

grounded in institutions and organizations which cross-cut the field of academic medicine.

In this dissertation I will use the term ‘institutional class positions’ to denote those varied and contingent positions emerging at the intersection of these five dimensions. Derived from two distinct theoretical frameworks, the matrix of ‘institutional class positions’ can be conceived as a field of conceptual vision which emerges when two analytical planes are superimposed on one another. At one level, we have an organizational plane of stratification, ranging from forms which are institution-specific to those which characterize all institutions of academic medicine to the fundamental organizational principles of modern organizations and labor markets. On the other level, there is a social plane which encompasses class-based, gendered, racialized, etc. patterns of differentiation. Here too, we find institution-specific arrangements, industry-wide patterns, and fundamental structures stretching across entire spheres of social and economic life. When these two broad structuring planes are superimposed upon one another, we get a matrix of cells, or ‘institutional class positions,’ most of which are quite small and specific. Table 1.1 gives several examples of concrete institutional class positions explored in my dissertation.

Several points must be made about ‘institutional class positions’ at the outset. While organizational and social planes of structuration can be distinguished analytically, numerous studies of gender, race and class in organizational hierarchies and occupational division of labor have shown that in practice the two are deeply intertwined. In a society stratified by class, gender, and race, organization of institutions and occupations is a gendered, racialized, and classed process. That is why, the seemingly incongruent levels of analysis – the macro-level divisions of class, race, and gender versus the micro-level institutionally specific organizational and

occupational hierarchies – must be brought together into a single analytical framework.

Table 1.1. *Institutional Class Positions – Examples and Sources*

Example of an institutional class position	Context in which this position was politically prominent	Main positioning factors	Discussed in chapter
Clinical Faculty, 1910s	Resisting and defeating the ‘full-time’ requirement during the 1910s	Institutional, occupational, class, professional ideology	3
Young clinical faculty, 1930s-1950s	Emerged as a leading interest in the expansion of ‘semi-private’ patient facilities in the decades before and after WWII	Age, class, occupational, organizational	4
Anesthesiologists in the 1930s	Formerly a nursing specialty, constituted a possible women’s professional niche, especially if entered from surgery	Gender, organizational, occupational, class	5
Minority physicians, 1910s-1970s	Discriminatory practices in medical education, academic and clinical appointments	Racial and ethno-religious identity, class, professional organizations	5
Social workers, 1960s-1970s	Pioneering unionization drive at Presbyterian Hospital during the 1970s	Occupation, gender, race, class, professional organizations	6
Physicians in the out-patient and emergency departments, 1970s	Espoused most radical vision of urban health care reform, centered around ‘one-class care’	Age, class, occupational, organizational	7

While the general matrix of ‘institutional class positions’ is quite durable, specific ‘institutional class positions’ may be more or less transient. The intersection of class, race, gender, occupation and organization structures most positions in the institutional terrain. However, the practical salience and visibility of ‘institutional

class positions' depend on whether they are articulated and activated by the processes of institutional change and conflict.

Conclusions and Implications

Two broad conclusions concerning American health care politics emerge from my work. First, private institutions of health care provision have actively constructed the health care system. They have been very important actors in the process of making those 'policies' which now characterize our regime of medicine and health care. During the first half of the twentieth century, these institutions, as well as various other actors associated with them, played far more leading roles in shaping the system than did formal political actors. In the second half of the past century, the power of academic medicine to shape the field of health care has declined as governments and corporations have increased their involvement. Yet, this decline should not be seen so much as a loss of power but instead as the result of a growing interpenetration of different institutional players, an interpenetration that has steadily reduced the space for political maneuver for everyone involved. The growing complexity and stalemate, therefore, have not resulted solely from the accommodating and incremental nature of political reform but also because of the enormous policy leadership of the private sector during the formative decades of the American health care system. This leadership continues to this day, albeit in a more constrained form. If there was a simple way to sum up this thesis, it would be that private institutions are policy-makers, too. Restricting the term 'policy-maker' to elected officials and executive agencies is a convention the usefulness of which has definite limits.

Second, private institutions of health care provision have participated in the making of health care policy not as monolithic, autonomous institutions but as internally contested and externally invested organizations. Academic medicine has not pursued simple or consistent policy goals throughout the century of health care

politics. Instead, there has been much internal conflict about where and how academic medicine, as well as health care in general, should develop. Multiple pressures and influences from outside of medical centers and academic medicine proper have also shaped the medical centers' development. My research suggests that this internal conflict and external influence is not easily comprehended with existing conceptual tools. In order to see them correctly, we need to conceptualize the structures of what I call 'institutional class positions,' constructed by the twin processes of institutional organization and social division.

Taken together, these findings suggest new ways of understanding the past and future of health care politics. Past policies have not emerged consensually and, while academic medical centers remain part of a conservative, or at least cautious, provider coalition, it might be possible to decouple some of their internal constituencies and then to enlist them in more progressive health care reform. If it is a broader coalition for the push for universal health insurance that we are looking for, there are a number of interests within academic medicine – from nurses to emergency care physicians to public health scholars to progressive administrators – which can be persuaded to join in efforts to steer our system in a more egalitarian, broadly beneficial direction. If it is a more constructive, endogenous development of the non-profit medical sector we desire, there are flawed governance structures and underrepresented groups which can be engaged to make these institutions more socially-responsive. In other words, whether we want to understand what has happened in health care politics or whether we want to do something about it, a closer look at the institutional politics of the private sector is a necessary first step.

CHAPTER 2

INSTITUTIONAL CLASS POSITIONS: APPLYING INTERSECTIONALITY AND MICRO-CLASS APPROACH TO THE STUDY OF PRIVATE HEALTH CARE POLITICS

Introduction

It has been widely acknowledged that the study of social and political processes should consider multiple and intersecting dimensions of social structure.¹ Numerous studies have bolstered the argument that class, race, and gender – to name the most salient dimensions of inequality – are interacting “systems of domination that affect access to power and privileges, influence social relationships, construct

¹ Intersectionality as a conceptual approach is most directly rooted in the activism and scholarship by women of color. Kimberlé Crenshaw was probably the first to employ the term itself in “Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics,” *Chicago Law Forum* (1989): 139-167, and “Mapping the Margins: Intersectionality, Identity, Politics and Violence Against Women of Color,” *Stanford Law Review* 43 (1991):1241-1299. Some of the earliest academic works to advanced the general proposition of intersectionality are: Angela Y. Davis, *Women, Race, and Class* (New York: Random House, 1981); Barbara Smith, ed., *Home Girls: A Black Feminist Anthology* (New York: Kitchen Table/Women of Color Press, 1983); Bonnie Thornton Dill, “Race, Class, and Gender: Prospects for an All-Inclusive Sisterhood,” *Feminist Studies* 9 (1983):129-50; bell hooks, *Feminist Theory: From Margin to Center* (Cambridge, MA: South End Press, 1984); Cherrie Moraga and Gloria Anzaldua, eds., *This Bridge Called My Back: Writings by Radical Women of Color*, 2nd ed. (New York: Kitchen Table Press, 1984); Gloria Anzaldua, *La Frontera/Borderlands: The New Mestizo* (San Francisco: Aunt Lute Books, 1987); Evelyn Nakano Glenn, “Racial Ethnic Woman’s Labor: The Intersection of Race, Gender and Class Oppression” in *Hidden Aspects of Women’s Work*, ed. Christine Bose et al (New York: Praeger, 1987); Deborah K. King, “Multiple Jeopardy, Multiple Consciousness: The Context of A Black Feminist Ideology” in *Black Women in America*, ed. M. R. Malson et al (Chicago: University of Chicago Press, 1988); Chandra Talpade Mohanty, “Under Western Eyes: Feminist Scholarship and Colonial Discourses,” *Feminist Review* 30 (Autumn 1988), pp. 61-88; Elizabeth V. Spelman, *Inessential Woman: Problems of Exclusion in Feminist Thought* (Boston: Beacon, 1988); Patricia Hill Collins, *Black Feminist Thought: Knowledge, Consciousness and the Politics of Empowerment* (New York: Routledge Press, 1990). [Rose M. Brewer, “Theorizing Race, Class, and Gender: The New Intellectual Scholarship of Black Feminist Intellectuals and Black Women’s Labor” in *Theorizing Black Feminisms: The Visionary Pragmatism of Black Women*, ed. Stanley M. James and Abena P.A. Busia (New York: Routledge, 1993)]. W.E.B. DuBois, Frantz Fanon, Max Weber, as well as feminist theory, women’s studies, and post-structuralism more generally, may be considered as intellectual precursors and relations of the intersectional approach.

meanings, and shape people's everyday experiences."² In the past, social scientists have often focused on a single dimension of stratification but such abstractions belied the multi-faceted nature of contemporary institutions, politics, and lived experiences.

The recognition of the multidimensional and intersecting structure of modern sociopolitical processes has had a major impact on scholarship across the social sciences. The intersectional approach gained particular currency in the study of institutional fields and practices, such as the legal system, the educational system, labor markets, and residential patterns.³ Students of health care and medicine have used the framework of intersectionality to study several issues, such as occupational structures and health disparities.⁴

² Esther Ngan-Ling Chow, "Introduction: Transforming Knowledge: Race, Class, and Gender" in *Race, Class, and Gender: Common Bonds, Different Voices* (New York: Sage, 1996), p. xix. Gender, race and class are most frequently correlated dimensions but, depending on a particular study, other factors – such as sexuality, ethnicity, region, religion, nativity, citizenship, disability, and age – have been included as well.

³ Joanne Belknap, *The Invisible Woman: Gender, Crime, and Justice* (Wadsworth Publishing, 2006); Carrie Yang Costello, *Professional Identity Crisis: Race, Class, Gender, and Success at Professional Schools* (Vanderbilt University Press: 2006); Richard Rothstein, *Class and Schools: Using Social, Economic, and Educational Reform to Close the Black-White Achievement Gap* (Economic Policy Institute, 2004); Samuel Walker, Cassia Spohn, Miriam DeLone, *The Color of Justice: Race, Ethnicity, and Crime in America* (Wadsworth Publishing, 2003); Ann Arnett Ferguson, *Bad Boys: Public Schools in the Making of Black Masculinity* (University of Michigan Press, August 28, 2001); Gregg Barak, Jeanne Flavin, and Paul Leighton, *Class, Race, Gender, and Crime: Social Realities of Justice in America* (Roxbury Publishing Company: 2001); Douglas Massey and Nancy Denton, *American Apartheid: Segregation and the Making of the Underclass* (Harvard University Press, 1998); Teresa Amott and Julie Matthaei, *Race, Gender and Work: A Multi-Cultural Economic History of Women in the United States* (South End Press, 1996).

⁴ Amy J. Schulz and Leith Mullings, eds., *Gender, Race, Class and Health: Intersectional Approaches* (Jossey-Bass, 2005); Nancy Krieger, ed., *Embodying Inequality: Epidemiologic Perspectives* (Baywood Publishing Company, 2004); Julian Tanner and Rhonda Cockerill, "Ideology and the Middle Class: The Influence of Work and Gender in the Health Care Professions," *Canadian Journal of Sociology*, Vol. 27, No. 4 (Autumn 2002), pp. 481-504; Tracey L. Adams, "Combining Gender, Class, and Race: Structuring Relations in the Ontario Dental Profession," *Gender and Society*, Vol. 12, No. 5 (October 1998), pp. 578-597; Shula Marks, "Divided Sisterhood: Race, Class, and Gender in the South African Nursing Profession," *The International Journal of African Historical Studies*, Vol. 29, No. 2 (1996), pp. 386-388; Madonna Harrington Meyer, "Gender, Race, and the Distribution of Social Assistance: Medicaid Use among the Frail Elderly," *Gender and Society*, Vol. 8, No. 1 (March 1994), pp. 8-28; Nona Y. Glazer, "Between a Rock and a Hard Place': Women's Professional Organizations in Nursing and Class, Racial, and Ethnic Inequalities," *Gender and Society*, Vol. 5, No. 3 (September 1991), pp. 351-372.

In this dissertation I apply the intersectional approach to analyze political processes within private health care organizations. In doing so, I draw on the several important insights which have emerged from intersectional studies. Class, race, gender and other categories of social division intersect to produce complex and multi-faceted forms of identity, membership, inequality and exclusion.⁵ Complex inequality is both reflected and actively constructed in organizational and institutional structures.⁶ Groups emerging at the intersection of multiple dimensions of difference provide frequent bases for both political mobilization and disempowerment.⁷ Divisions based in race, gender and class figure prominently as both strategic devices and concrete effects of politics and policy.⁸

⁵ There is a large literature on these subjects, particularly in anthropology, sociology, history, and the humanities. For intersectionality in the formation of political identities, see, for instance: Evelyn Nakano Glenn, *Unequal Freedom: How Race and Gender Shaped American Citizenship and Labor* (Harvard University Press, 2002); Sonya O. Rose and Kathleen Canning, eds., *Gender, Citizenship and Subjectivities* (Blackwell Publishing, 2002); Barbara Hobson, ed., *Gender and Citizenship in Transition* (Routledge, 2000); Anthony W. Marx, *Making Race and Nation: A Comparison of the United States, South Africa* (Cambridge University Press, 1998); Jennifer Hochschild, *Race, Class and the Soul of the Nation* (Princeton University Press, 1995).

⁶ See, for example, Mary Fainsod Katzenstein, *Faithful and Fearless: Moving Feminist Protest inside the Church and Military* (Princeton University Press, 1999); William M. Dugger, ed., *Inequality: Radical Institutional Views on Race, Gender, Class, and Nation* (Greenwood Press, 1996); Robert L. Nelson and William P. Bridges, *Legalizing Gender Inequality: Courts, Markets and Unequal Pay for Women in America* (Cambridge University Press, 1999).

⁷ Kimberly Springer, *Living for the Revolution: Black Feminist Organizations, 1968-1980* (Duke University Press, 2005); Benita Roth, *Separate Roads to Feminism: Black, Chicana, and White Feminist Movements in America's Second Wave* (Cambridge University Press, 2003); Sharon Kurtz, *Workplace Justice: Organizing Multi-Identity Movements* (University of Minnesota Press, 2002); Cathy Cohen, *The Boundaries of Blackness: AIDS and the Breakdown of Black Politics* (Chicago: University of Chicago Press, 1999).

⁸ Ira Katznelson, *When Affirmative Action Was White: An Untold History of Racial Inequality in Twentieth-Century America* (New York: W. W. Norton, 2005); Suzanne Mettler, *Dividing Citizens: Gender and Federalism in New Deal Public Policy* (Ithaca, NY: Cornell University Press, 1998); Jill Quadagno, *The Color of Welfare: How Racism Undermined the War on Poverty* (New York: Oxford University Press, 1996); Theda Skocpol, *Protecting Soldiers and Mothers: The Political Origins of Social Policy in United States* (Cambridge, MA: Belknap Press, 1995); Gwendolyn Mink, *The Wages of Motherhood: Inequality in the Welfare State, 1917-1942* (Ithaca, NY: Cornell University Press, 1995); Margaret Weir et al, eds., *The Politics of Social Policy in the United States* (Princeton, NJ: Princeton University Press, 1988).

While enormously influential, the theory of intersectionality raises many new issues and questions. The importance of gender, race, or class in determining individual situations and political structures may vary independently of the others. This variation is likely to depend on the specific topic studied, the questions posed, and the sociohistorical context. That is, while gender, race and class all matter, the salience of one over another is an empirical question. We must also consider the possibility of reinforcing yet contingent relationships between the different systems of stratification. Are racialized subjects also gendered? Is class system racialized? Do women occupy separate and gendered class locations? Always? Sometimes? How?

One of the frequent criticisms leveled at the intersectional studies is the failure to specify and justify the particular definitions of intersecting dimensions. Class, gender, and race have been and continue to be conceptualized in many different ways and, when we invoke any of them, it is not immediately clear how they are being defined. Moreover, it cannot be assumed that these several terms can be seamlessly and unproblematically combined into a common conceptual framework. After all, class, race, and gender have often been defined as separate and competing conceptualizations of social structure and politics. Thus, defining the concepts and outlining their relationships with one another is an indispensable first step of intersectional analysis. Depending on the subject and method of study, the key intersectional categories may have to be defined and related to each other in different ways.

The organization of this chapter reflects the imperative to provide just such a conceptual foundation for an intersectional study. I begin with the concept of class, as both the most contentious subject in the social sciences today and also the most under-theorized dimension in the studies of intersectionality. I argue that the neo-Durkheimian concept of ‘micro-classes,’ proposed in the work of David Grusky and

his collaborators, is the best point of departure for a study concerned with intra-institutional politics of complex professional organizations. It is also, in my view, the most compatible with the intersectional approaches to the study of institutional and political processes.

While very fruitful, the neo-Durkneimian perspective insufficiently questions the conflation of occupations and classes. I argue that the effort to ‘disaggregate’ traditional class categories should proceed from the categories emerging at the intersection of occupational and class structures, rather than from occupations or occupational associations as such. To the intersection of class and occupation, it is necessary to add a third dimension central to modern social structures: organizational rank or ‘organization,’ for short). Distinguished and defined, the dimensions of class, occupation, and organization must ultimately be related to each other. To do this, I draw on the studies of the middle class and the professions to offer a preliminary conceptual blueprint for my dissertation.

In the second half of this chapter I tackle the concepts of gender and race. Arising as it did from the work of women of color, the concept of intersectionality has been particularly strong in theorizing the nexus of gender and race. In regard to gender, then, I focus my attention on its relationship with the *other* three dimensions of my framework, namely, occupation, organization, and class. The conceptualization of race, however, has been, if anything, too closely intertwined with, and frequently subordinated to, class and other structural principles. My review of race theory focuses on those works which sharpen our understanding of race as an autonomous structuring principle.

I conclude this chapter by recapitulating the five-dimensional analytical framework and propose the term ‘institutional class positions’ to designate those

identities, groups, and strategies that emerge at the intersection of occupation, organization, class, gender, and race.

Class

The concept of class has always been a contested idea. In recent decades it came under a new round of attacks from those who believe classes have largely dissolved in contemporary societies and that class is no longer useful as a category of social and political analysis. At the same time, many scholars have rushed to defend class, both as a continuing social reality and as an analytical tool.⁹ More interesting than the debate itself have been various recent efforts to rethink the concept of class from within the various traditions of class analysis. An important aspect of this rethinking has been increasing eclecticism and hybridity of class analysis registered in the willingness of researchers to combine the elements of Marxist, Weberian and other distinct approaches. There is also a growing recognition of the need for methodological pluralism within the class analytic enterprise. An editor of a recent volume that brought together the advocates of neo-Marxist, neo-Weberian, neo-Durkheimian, Bourdieuan, 'rent-based' and 'post-class' approaches concluded that different approaches have different strengths and that different concepts of class may be more or less suitable to particular analytical questions. Thus, "[a] concept [of class] whose task is to help answer a question about broad historical variations in the social organization of inequality is likely to be defined quite differently from a concept

⁹ See, for instance, Terry Nichols Clark and Seymour Martin Lipset, "Are Social Classes Dying?" *International Sociology* 6 (December 1991), pp. 397-410; Jan Pakulski and Malcolm Waters, *The Death of Class* (London: Sage, 1996); Paul W. Kingston, *The Classless Society* (Stanford, CA: Stanford University Press, 2000); Terry Nichols Clark and Seymour Martin Lipset, eds., *The Breakdown of Class Politics: A Debate on Post-Industrial Stratification* (Washington, D.C.: The Woodrow Wilson Center Press, 2001).

[of class] used to answer a relatively narrow questions about the subjective identity of individuals in contemporary society.”¹⁰

Scholars of modern organizations and their politics have frequently noted the salience of class among other dimensions of structural inequality. Conventional class theory, however, constructed class at a highly aggregate level that made it difficult to apply to the micro-politics of organizations. The problem was especially acute in regard to those organizations which included sizable numbers of professions whose class location and character were far from clear. For the purpose of research focused on the intra-institutional politics, a highly disaggregated concept of class is in order. The strongest case for conceptual disaggregation has been proposed by David Grusky and his collaborators.¹¹ They view their approach as a neo-Durkheimian alternative to the ‘death of class’ thesis that points to “the persistence of class-like structuration at a more disaggregate level than class analysis have typically appreciated.” Instead of abandoning class as an important dimension of social structuration, this approach insists that “the labor market is indeed organized into classes, albeit in a more detailed level than is conventionally allowed.” The advantage of the resulting “micro-classes” is their greater realism: they are “embedded in the very fabric of society and are thereby meaningful not merely to social scientists but to the lay public as well.”¹²

¹⁰ Erik Olin Wright, ed., *Approaches to Class Analysis* (Cambridge, UK: Cambridge University Press, 2005), p. 180.

¹¹ David B. Grusky in collaboration with Gabriela Galescu, “Foundations of a Neo-Durkheimian Class Analysis” in *Approaches to Class Analysis*, ed. Erik Olin Wright (Cambridge, UK: Cambridge University Press, 2005); David B. Grusky and Jesper B. Sørensen, “Can Class Analysis Be Salvaged?,” *American Journal of Sociology* Vol. 103, No. 5 (1998), pp. 187-134, and “Are There Big Classes?,” in *Social Stratification: Class, Race, and Gender in Sociological Perspective*, 2nd ed., ed. David B. Grusky (Boulder, CO: Westview Press, 2001); David B. Grusky and Kim A. Weeden, “Decomposition without Death: A Research Agenda for a New Class Analysis,” *Acta Sociologica* 44 (2001), pp. 203-18; David B. Grusky, Kim A. Weeden, and Jesper B. Sørensen, “The Case for Realism in Class Analysis,” *Political Power and Social Theory* 14 (2000), pp. 291-305.

¹² David B. Grusky with Gabriela Galescu, “Foundations of a Neo-Durkheimian Class Analysis,” pp. 51-52.

Durkheim argued that occupational associations are destined to become the main organizational form “intercalated between the state and the individual,” supplanting both Marxian classes and other forms of intermediary organization. For Grusky and his collaborators, this prediction has been largely borne out. Industrial conflict at the macro-class level has indeed been contained, while “occupational groupings have emerged as the elementary building blocks of modern and postmodern labor markets.”¹³ Contemporary workers routinely represent their career aspirations in occupational terms, while professional and vocational schools are organized to train workers for occupationally defined skills, and employers construct and advertise jobs in terms of corresponding occupational designations. This “occupationalization” of the labor market has been fueled by (1) a long-term growth in the size of the professional sector, (2) the rise of new quasi-professional occupations and their associations, (3) increasing use of licensing, certification, and similar devices, and (4) the strengthening of local labor unions.¹⁴

Unlike other approaches attentive to occupations, the neo-Durkheimian perspective focuses on ‘detailed occupations’ and ‘occupational organizations,’ rather than on aggregates of occupational categories. Pitched at this micro-level, occupations exhibit powerful structuring effects. They tend to “act collectively on behalf of their interests, to defend their boundaries and thereby secure (partial) closure, to define lifestyles and consumption practices that are binding on members, and to become subjectively meaningful categories through which workers perceive themselves as well as others.”¹⁵

¹³ *Ibid.*, p. 61.

¹⁴ *Ibid.*

¹⁵ *Ibid.*, pp. 71-72.

While the shift toward a disaggregated concept of class is very promising, the particular conception of ‘micro-classes’ adopted from Durkheim unhelpfully conflates the occupational and class structures.¹⁶ On the one hand, Grusky and his co-authors assert that “occupations ... behave precisely as class theorists have long thought aggregate classes should.”¹⁷ At the same time, occupational associations “crowd out or substitute for class formation of amore aggregate sort.” Their rise is directly linked with the decline of ‘big classes’ insofar as they “undermine the unity of the working class” and “convince workers to regard occupational differences in remuneration (including those between big classes) as appropriate and acceptable.” In fact, argue the authors, “ [i]f there is a class analytic theory of history in Durkheim, it is clearly one that emphasized the role of occupations in justifying inequality, making it palatable, and hence undermining the more spectacular theories of history that Marx and various neo-Marxians have advanced.”¹⁸

Occupational associations are, thus, both ‘class-like’ and ‘anti-class.’ They both fulfill a range of functions conventionally ascribed to classes and, at the same time, supplant and suppress the formation of ‘large classes.’ In this analysis, occupational associations and class organizations are distinct and competing forms. ‘Large classes’ may be fading as concrete historical groups, but class remains a valid analytical category. In fact, it is only on the basis of the ‘traditional’ conception of class that Durkheim can critique occupational associations as masking and justifying inequality. It is, thus, rather misleading to suggest that occupational associations

¹⁶ The following limitations of Durkheimian theory are noted by Grusky and his collaborators: (1) occupational associations have not displaced all other competing associational forms; (2) occupational organizations have failed to emerge in some sectors; (3) there is much cross-national variation in the extent to which the labor market has become occupationalized. In regard to the last point, while Germany and the United States fit into the Durkheimian model very well, Japan and, especially, Sweden, pose serious challenges to it. [*Ibid.*, pp. 62-65.]

¹⁷ *Ibid.*, p. 67.

¹⁸ *Ibid.*, p. 57.

replace classes in an analytical sense. As proponents of the neo-Durkheimian class analysis admit, the occupational associations have not entirely supplanted other competing forms of social structuration. In fact, they both exist in competition with other forms and exhibit internal tensions stemming from suppression of inequality and conflict within their own ranks. In my view, the project of disaggregating class analysis is better positioned at the level of intersection between occupations and classes, rather than at the level of occupations only.

Occupation

The relationship between occupations and classes has long been a prominent question in the social sciences. The dominant paradigm in post-war American social science – structural functionalism – theorized occupational stratification as a reflection of their functional importance resting on a broad social consensus regarding its legitimacy. In this perspective, occupational differentiation supplanted both social classes and social conflicts arising from class division.¹⁹ Although the ‘functional-consensual’ school often claimed Weberian roots, a different stream of Weberian scholarship rejected its basic presuppositions, arguing that the social organization at large and the occupational structure in particular were characterized by conflict rather than consensus and monopolization rather than functionality.²⁰ In this view, the alleged moral consensus, which the consensual-functionalist scholarship gleaned from

¹⁹ K. Davis and W. E. Moore, “Some Principles of Stratification,” *American Sociological Review* 10, pp. 242-249; P. Blau and O. D. Duncan, *The American Occupational Structure* (New York: John Wiley, 1967); R. W. Hodge, P. M. Siegel and P. H. Rossi, “Occupational Prestige in the United States: 1925-1963,” *American Journal of Sociology* 70 (1964), pp. 286-302; R. W. Hodge, D. J. Treiman and P. H. Rossi, “A Comparative Study of Occupational Prestige” in *Class, Status and Power*, ed. R. Bendix and S. M. Lipset, 2nd ed. (London: Routledge, 1967).

²⁰ Ralf Dahrendorf, *Class and Class Conflict in Industrial Society* (Stanford: Stanford University Press 1959); Michael Mann, “Social Cohesion of Liberal Democracy,” *American Sociological Review* 35 (1970), pp. 423-439; Frank Parkin, *Class Inequality and Political Order: Social Stratification in Capitalist and Communist Societies* (New York: Praeger, 1971) and *Marxism and Class Theory: A Bourgeois Critique* (New York: Columbia University Press, 1979); Anthony Giddens, *The Class Structure of the Advanced Societies* (London: Hutchison, 1973).

the consistent ranking of occupational prestige, indicated nothing more than a general awareness of occupational inequality, by no means equivalent to its endorsement.

Despite their common rejection of the functionalist-consensual interpretation of occupational structure, Weberian and Marxist traditions of class analysis have nevertheless produced a broad range of theories relating occupation and class. Some theorists have insisted on a sharp distinction between occupational and class structures, as divisions deriving from technical and social relations of production respectively.²¹ Other class theorists have tended toward the view of ‘occupations’ and ‘classes’ as nearly identical categories of modern stratification.²² Neither of the two positions proved satisfactory.

To equate occupations with classes is to uncritically accept the myth of economic and status homogeneity of occupations, a view which many professional organizations would like to promote. Regardless of how one defines class position –

²¹ Wright, for example, argued that occupations are defined by a host of technical functions and activities: “a carpenter transforms lumber into buildings; a doctor transforms sick people into healthy people; a typist transforms blank paper into paper with words on it, etc.” Classes, on the other hand, can only be defined “in terms of their social relationship to other classes, or in more precise terms, by their location within the social relations of production.” In short, occupations are positions defined within the *technical* relations of production, while classes are positions defined within the *social* relations of production. [Erik Olin Wright, “Class and Occupation,” *Theory and Society* 9, no. 1 (1980), p. 177.] Abercrombie and Urry made a similar distinction between occupation and class as aspects of *technical* and *social* division of labor respectively to argue that ‘occupation’ does not grasp the essential components of the Marxist concept of ‘class.’ [Nicholas Abercrombie and John Urry, *Capital, Labour and the New Middle Classes* (London: Allen & Unwin, 1983), p. 109.] Another example is Goldthorpe and his collaborators who have pointed out that one and the same occupation may be located in different class positions. A plumber, for example, may be a “self-employed plumber,” a “foreman plumber,” or a “rank-and-file employee,” each corresponding to a distinct class position. [John H. Goldthorpe with Catriona Llewellyn and Clive Paine, *Social Mobility and the Class Structure in Modern Britain*, 2nd ed. (Oxford: Clarendon Press; New York: Oxford University Press, 1987), p. 40.]

²² Parkin, for instance, argued that “[t]he backbone of the class structure, and indeed of the entire reward structure of modern Western society, is the occupational order. Other sources of economic and symbolic advantage do coexist alongside the occupational order, but for the vast majority of the population these tend, at best, to be secondary to those deriving from the division of labor.” [Parkin, *Class Inequality and Political Order*, p. 18.] In a similar vein, Reid defined social class as “a grouping of people into categories on the basis of occupation.” [Ivan Reid, *Social Class Differences in Britain* (London: Grant McIntyre, 1981), p. 6.]

whether as life chances, combination of income, education, and wealth, or as a relationship to the means of production – it would be misleading to suggest that members of the same occupation necessarily belong to the same class. Even in the case of such prestigious and selective professions as medicine and law, the differences in income and wealth among American physicians or lawyers point away from a presumptive equivalence between occupation and class position. Occupational titles are not reliable indicators of capital and wealth ownership or of organizational position. Equating class and occupational structures obscures relations of property and authority, which retain fundamental importance to the economic, political, and social balance of power.²³

The categorical distinction between occupations and classes cannot be sustained either. During the early 20th century, the occupation of a ‘typist,’ for instance, had been clearly defined as a lower-middle class, white, unmarried female occupation. In fact, the occupation may not have emerged at all as a separate work function, had not this particular social category of worker been available to fill it.²⁴ To say that occupations are positions defined by the technical division of labor is tantamount to suggesting that some kind of system of technical rationality operates alongside and independently of the system of power relations. On the contrary, most ‘technical’ innovations in the division of labor crucially depended on the particular qualities of a given class structure. For instance, occupations which emerged in various modern manufacturing industries, just as a system of factory labor as a whole, were premised on the decimation of small-holding peasantry and the rise, out of its ranks, of unskilled proletarian masses. Most positions in the modern ‘technical’

²³ John Westergaard, *Who Gets What?* (Cambridge: Polity Press, 1995).

²⁴ Sharon Hartman Strom, *Beyond the Typewriter: Gender, Class and the Origins of Modern American Office Work, 1900-1930* (University of Illinois Press, 1992).

division of labor have been and continue to be profoundly shaped by the interests of the dominant class of capitalist employers. Conversely, most occupations – whether through professional associations, trade unions, or both – have tried to influence their ‘technical’ specification and organizational position in order to boost the socio-economic standing of their members.²⁵

Some of the most productive work in theorizing the relationship between occupations and classes emerged from the studies of the professions and the middle class.²⁶ Notably, mixed and eclectic approaches have become quite common in these areas of scholarship.²⁷ An important step toward a non-reductive theorizing of modern professional-managerial class involved identification of the unique economic and institutional bases of its formation. Economically productive knowledge, educational credentials and cultural capital more generally have been proposed as chief assets underwriting the social formation of the modern professional middle class, while the

²⁵ Althusser has succinctly expressed what I take to be an appropriate attitude of suspicion with regard to categorical distinction between occupation and class, arguing that “... there is no ‘technical division’ of labour except in the ideology of the ruling class: every ‘technical’ division, every ‘technical’ organization of labour, is the form and mask of a *social* (= class) division and organization of labour.” (Althusser, “Ideology and Ideological State Apparatuses (Notes Towards an Investigation)” in *Mapping Ideology*, ed. Slavoj Žižek (London: Verso, 1994; reprinted in translation from Louis Althusser, *Essays on Ideology* [London: Verso, 1984]), p. 137.) This may be a bit too stark because it is not inconceivable that the development of technique may have some contingent degree of autonomy from principal structures of determination. Nevertheless, both development and application of productive techniques are so closely intertwined with ‘non-technical’ interests of the powerful social actors as to make any clear-cut distinction quite impossible.

²⁶ See, for example, Mike Savage et al, *Property, Bureaucracy and Culture: Middle-Class Formation in Contemporary Britain* (London: Routledge, 1992) and Anne Witz, *Professions and Patriarchy* (London: Routledge, 1992).

²⁷ Comparing Marxist and Weberian approaches, Abercrombie and Urry noted that “[o]n the one hand, Marxists have been right to emphasize the increase in the degree to which professionals function for capital, as constitutive elements of the service class; yet on the other hand, Weberians have been correct to emphasize the distinctive market position of professionals which stems in part from their ability to regulate their particular knowledge-base.” [Abercrombie and Urry, *Capital, Labour and the New Middle Classes*, p. 147.] Turner argued likewise that “a satisfactory explanation of professionalization as an occupational strategy will come eventually to depend upon both Weberian and Marxist perspectives.” [Bryan S. Turner, *Medical Power and Social Knowledge* (Sage, 1987) pp. 139-140.]

modern system of higher education has been consistently identified as a central institutional mechanism of their appropriation and reproduction.²⁸

Larson's 1977 study of professionalization developed one of the most cogent statements on the relationship between occupations and classes, which has been increasingly recognized as a crucial theoretical foundation for work in this area.²⁹ For Larson, the rise of modern professions is inextricable from the larger process of emergence of a new system of social stratification. Professions and professional ideologies arose as a part of the formation of the new, urban middle classes "whose identity was founded on the educational system and on their occupation in modern and typically bureaucratized work settings."³⁰ Stressing the organic connection between professional and middle-class identities, Larson argued that

[i]n the Progressive Era, sectors of the intermediate class whose self-definition and self-esteem were increasingly based on occupation, and increasingly oriented toward national frames of reference, acquired something akin to class consciousness. Professionalism was one expression of this consciousness.³¹

At the same time, professional projects were implicated in a set of processes that went beyond the restructuring of the middle social strata. Professionalization, for Larson, is a historical counterpart of proletarianization in a sense that, "[a]s the labor force tends to become totally subsumed under the formal relations of capitalist production, the real and the ideological privileges associated with 'professionalism' legitimize the class structure by introducing status differentials, status aspirations, and status mobility at

²⁸ Alvin W. Gouldner, *The Future of Intellectuals and the Rise of the New Class* (New York: Oxford University Press, 1979); Parkin, *Class Inequality and Political Order*; Pierre Bourdieu, *The State Nobility: Elite Schools in the Field of Power*, trans. L. C. Clough (Cambridge: Polity Press).

²⁹ Magali Sarfatti Larson, *The Rise of Professionalism: A Sociological Analysis* (Berkeley: University of California Press, 1977).

³⁰ Larson, *The Rise of Professionalism*, p. 200.

³¹ *Ibid.*, p. 154.

practically all levels of the occupational hierarchy.”³² Class and status interests have been closely intertwined in the professional projects of the new middle classes. “The double nature of the professional project intertwines market and status orientations,” argued Larson, “and both tend toward monopoly – monopoly of opportunities for income in a market of services, on the one hand, and monopoly of status in an emerging occupational hierarchy, on the other.” Both of these quests – for privileged class position and elevated social status – have found their principal institutional foundation in “the educational system.”³³

While stressing considerable gains in collective mobility achieved by many professional projects, Larson concluded that, ultimately, the modern professional became “a choice victim” of the ideology of its own success. “Professionalism,” she stressed, “functions as a means for controlling large sectors of educated labor and for co-opting its elites.” Even in a profession as powerful as medicine, Larson concluded, “the general measures of success and power ... tend to flow, ultimately, from outside, from the central power structure of society.” The extent of material rewards and status honor, which professions secure for their members, often obscures substantial inequalities which persist within and among the professions. For the lower rungs of professional workers “the individual freedom and control which professionals enjoy in and out of work is in part a mask: for themselves as well as for less privileged others, it helps to conceal collective powerlessness, subordination, and complicity.”³⁴

Institutional, as well as ideological, aspects of professionalism constitute a carefully calibrated structure of incentives and controls *within* and *between* occupations. While crucial to the overall system of class relations, mechanisms of

³² *Ibid.*, p. 239.

³³ *Ibid.*, p. 79.

³⁴ *Ibid.*, pp. 225, 237, 236, 243.

professional control and its attendant ideologies obviate the distinction between inter- and intra-class relations. The same mechanisms which secure the compliance of junior and lower-level professionals operate within the larger field of occupational and class differentiation. Conversely, the mechanisms, by which credentialed occupations separate themselves as a whole from non-credentialed labor, also secure internal differentiation among the credentialed strata. The crucial structures which institutionalize and reproduce these mechanisms are modern organizations.

Organization

Another limitation of the neo-Durkheimian approach proposed by Grusky and his collaborators is its neglect of vertical organizational structures in which the majority of modern workers are employed. The authors are not unaware of this problem. In fact, they raise the question of whether, as postindustrialism evolves, vertical methods of control will continue to encroach on occupationally defined labor through task fusion, elaboration, and complication. Their answer is that modern economic trends, including the growth of outsourcing, downsizing, and externalization, actually increase pressures to identify and affiliate with occupations rather than organizations. But, again, this issue does not require an ‘either/or’ approach. Occupational and organizational logics of social organization have been long intertwined and will likely remain so for the foreseeable future.

The affinity between bureaucracy and professions was already apparent at the turn of the century: both were crucial to the process of economic rationalization and found their crucial source of legitimation in educational credentialism. As Weber noted, the modern form of “examination for expertise,” which was rapidly becoming the primary method of appropriating bureaucratic positions, “is found also outside the strictly bureaucratic structures ... in the so-called ‘free’ professions of medicine and law.” The common foundation, which organizational and professional monopolies

have in the modern system of education, fulfills an important ideological role. The allegedly “open” educational system disguises class- and status-based monopolies in the appropriation of professional and bureaucratic positions with universalistic legitimations. Although this “system of examinations means, or at least appears to mean, selection of the qualified from all social strata,” in actuality, it tends toward a form of monopolization, in which the propertied classes are favored.³⁵

In post-war social science, however, a distinction – even opposition – between professions and bureaucracy, rather than affinity, became the reigning paradigm. At the most basic level, it has been conceived as a conflict between two opposing social imperatives: the impersonal, routinizing, and authoritarian world of bureaucracy, on the one hand, and the creative, sophisticated, and autonomous work of professionals, on the other.³⁶ This antinomy between bureaucracy and professions raised many questions, since post-war growth of professionals in the labor force was almost entirely constituted by professionals who worked within large organizations or had organic connections to them.

In a society saturated with large, bureaucratic organizations, the view of the professions as inherently anti-bureaucratic was bound to be dispelled sooner or later. As empirical studies of bureaucracies and professions challenged their ideal concepts, it became increasingly clear that the theorized opposition between them was based on a stereotyped view of bureaucratic organizations and a largely mythical conception of the “free” professions, which exaggerated the autonomy of its practitioners. The majority of professionals are connected with bureaucratic organizations as employees,

³⁵ Weber, *Economy and Society*, quotes from pp. 999-1000, also see pp. 141, 306.

³⁶ See, for example, Robert K. Merton, “Bureaucratic Structure and Personality,” *Social Forces* 17 (1940), pp. 560-568; Alvin Gouldner, “Cosmopolitans and Locals,” *Administrative Science Quarterly* 2 (1957-1958), pp. 281-306 and 444-480; Eliot Freidson and Buford Rhea, “Processes of Control in a Company of Equals,” in *Medical Men and Their Work*, ed. Eliot Freidson and Judith Lorber (Chicago: Aldine-Atherton, 1972).

contractors, providers of services, or users of equipment or facilities. Moreover, every profession which has successfully established its claim to expertise and control over selection and training of practitioners is also connected with the modern university, a bureaucratized institution in which a critical period of professional socialization takes place. Although occupations are usually too loose and heterogeneous to be considered ‘organizations,’ their projects of professionalization and collective mobility have been crucially bound with their *organizational* efforts.³⁷

In the case of many modern professions – such as accounting, social work, school-teaching, or nursing – the very professionalization was crucially dependent on the prior existence of organizations developing their particular field of work. Bureaucratization frequently promoted a rational organization of work, including the development of specialized expertise. In turn, the bureaucratically-created specialists pushed for further development of their fields of expertise, striving to give them a measure of independence from particular employing organizations. To succeed, professional projects originating within heteronomous organizations required the creation of external sources of certification and expertise, such as professional schools, associations, and state licensing boards, in order “to introduce into the career patterns of one organization checks that are administered by other organizations.”³⁸ But modernization of older, independent professions was also crucially dependent on establishing the triple base resting on the relationship between external employing organizations, the modern university, and the state. Modernization of the medical profession, for instance, is unthinkable without an ensemble of hospital, university, and state boards at its foundation.

³⁷ Larson, *The Rise of Professionalism*, p. 69.

³⁸ *Ibid.*, pp. 184-185.

The fact that bureaucratization of many functional activities directly stimulated the emergence of new professional tasks and, ultimately, professions, points to the fact that bureaucratic organizations and professional occupations rest on shared cognitive presuppositions. As Larson noted, “both professions and bureaucracy rest on a certain measure of cognitive standardization, for both pretend to allocate people to work roles on the ‘rational’ basis of ‘objectively’ tested competence: ‘objectivity’ requires that the content of such tests be specific, specified, and homogeneous, as well as accessible in principle to ‘all who would care to learn.’” While the possession of an independent cognitive base has been identified as a distinguishing characteristic of the professions, bureaucratic organization can also be seen as a cognitive field informing both a specific activity of modern administration and an organization of a broad range of other complex fields of work.

Professions and organizations can also be seen as complementary modes of securing positions in the division of labor. As Savage and his collaborators argue, professionalism is an attempt to translate cultural assets, systematized in a specific body of knowledge, into material rewards. However, professional knowledge generated within the institutions of higher learning “needs to be transformed in the work situation to become useful practical knowledge.” Large-scale organizations have proven to be “indispensable for translation of professional knowledge into status-appropriate incomes.” Organizational occupations, on the other hand, face the opposite challenge of broadening and generalizing their “organization-specific” knowledge so that it may be more easily transferred across different employing contexts. Establishment of external means of training and certification is a primary way to achieve a higher degree of autonomy from particular employing organizations. Thus, “while unqualified workers in organizations pursue ‘professional projects’ to allow them a more secure base to perpetuate or develop their advantages, workers with

cultural assets pursue ‘organizational projects’ in order to find employment in specific organizations which allow their skills to earn rewards.”³⁹

The historical nexus between professionalism and corporate capitalist enterprise exposes yet another aspect of the relationship between occupational and organizational structures. In his study of corporate capitalism, Chandler noted that the most dynamic and flexible among the emergent monopolistic corporations arrived independently at the same organizational innovation – the multidivisional structure – which gave these enterprises unprecedented capacity to use and accommodate expert and professional staff workers.⁴⁰ Within this new, vast, and decentralized structure of capitalist production, professionalism, Larson argued, was not simply a culture to be accommodated; it also functioned as a critical mechanism of organizational control. Where hierarchical bureaucratic methods of control were incompatible with the autonomy required for innovative professional work, professionalism could function as a substitute system for making the use of professional discretion more predictable. Corporate and professional structures become, here, mutually supportive: “expertise is implicitly proposed as a legitimation for the hierarchical structure of authority of the modern organization; professionalism, in turn, functions as an internalized mechanism for the control of the subordinate expert.” In such a structure, argued Larson, “[t]here need be no basic conflict between the professional expectation of autonomy ... and

³⁹ Mike Savage et al, *Bureaucracy and Culture: Middle-class Formation in Contemporary Britain* (London: Routledge, 1992), pp. 22-23. This ‘symmetrical’ view of professional and organizational projects does not hold in all cases. Organizations were a mixed blessing at best to those professions, like medicine, which could market their services directly to consumers. The enthusiasm for organizational projects was generally confined either to those sections of the professions which either could not or would rather not sell their services directly to consumers (i.e. medical scientists) or to the younger elite urban professionals who had high chances of enhancing their prestige through organizational affiliation. It is only when monopoly capital, which underwrote most large organization-building, thoroughly transformed these professional fields, augmenting the value of professional labor in organizations to such an extent as to undermine independent practice, that organizational and professional ‘tendencies’ within these occupations have become more or less balanced.

⁴⁰ Alfred D. Chandler, *Strategy and Structure* (Cambridge, Mass.: MIT Press, 1962).

large-scale bureaucratic organizations ... unless, of course, professionals are more interested in *power* than in autonomy of technique.”⁴¹

Taken together, the analyses of the links between the professions, on the one hand, and the educational system and large-scale bureaucratic employing organizations, on the other, allowed Larson to formulate the relationship between occupational and organizational structures in a more general way. She argued that: (1) “relations between professions and specific bureaucratic organizations are a most powerful determinant of stratification *among* professions and *within* professions” and (2) they constitute a crucial mechanism by which professions are incorporated into the structure of contemporary capitalism.⁴²

Economic and social status discrepancies among occupations are reflected in their relationship with the system of higher education. Institutionalization of an occupation’s cognitive base within the modern university is a crucial benchmark on the path to professional status. Unequal resources and prestige of the academic disciplines, however, reflect and perpetuate disparities between the professionals they train or support. In addition to differences between professional disciplines, all of the units in the system of higher education – universities at large, their separate schools, and the departments within those schools – are themselves subject to rating in a recognized system of hierarchical prestige. Even though all of these units offer standardized and certified programs of instruction, the importance of attending the more prestigious schools is clear to all. As Larson noted, “in terms of social connections, and especially in terms of ideology, elite schools socialize their graduates

⁴¹ Larson, *The Rise of Professionalism*, pp. 198-199.

⁴² *Ibid.*, pp. 203, 189-190.

into an elite.”⁴³ The system of higher education, with its multiple levels of prestige both between and within institutions,

operates as a switchboard to the world of work, but as a switchboard that would, at the same time, determine the distance and the speed of the trains. The trains are different classes of colleges, universities, and professional schools at which the passengers arrive after having been filtered by a number of other switchboards.⁴⁴

The processes of professional stratification do not end with the completion of professional training but operate throughout the markets for professional services and at every stage of professional careers. In the world of professional employment, organizations stratify occupations in two ways: through an internal hierarchy of jobs and through an external ranking of organizations. First, various forms of hierarchical bureaucratic organization standardize and legitimize the inequality between individual professionals within employing organizations. Secondly, dependence on heteronomous employing organizations creates a kind of ‘externally produced’ differentiation, which “stratifies the professions from the outside, pulling chosen professional institutions and chosen professionals toward the centers that control power and resources, while relegating others to marginality.” With the decline of the free professional, intra-occupational inequality is increasingly bound with the rankings of organizations training and employing credentialed workers: “doctors are identified with their hospitals, lawyers, architects, and engineers with their firms, and every professional with his academic origins.”⁴⁵

In virtue of their dependence on capitalist enterprises, private organizations, and the state for the financing of training and research and the provision of

⁴³ *Ibid.*, p. 204.

⁴⁴ *Ibid.*, p. 201.

⁴⁵ *Ibid.*, pp. 205, 72.

employment, professional occupations are firmly integrated into the larger power structure of society. The network of training and employing organizations, which certify and validate educational credentials, demarcates credentialed from uncredentialed workers and further differentiates the levels of income and prestige among the credentialed workers. The hierarchy of organizations and the hierarchy of positions within organizations establish a structure of occupational inequality. The resulting 'organization of organizations' is the chief matrix of class positions and trajectories in a credentialed society.⁴⁶

Gender

Although multiple and overlapping logics of differentiation are implicit in Larson's framework, she does not address directly how other salient social divisions – such as those of gender and race – structure the institutional matrix of social

⁴⁶ Larson's model emphasizes the temporal aspect of the functioning of the modern class-organizational matrix, denoted by the modern notion of a career. She argues that the institutionalization of the passage from professional training to professional practice is a basic condition of the emergence of modern professional careers. Through it, modern career becomes a powerful means of control over successive cohorts of actual and potential entrants into the ranks of credentialed labor force. The practical effectiveness of control over professional recruits is rooted in the costs and rules of professional careers. Since most professional fields have erected substantial barriers to entry, in the form of lengthy and expensive training prerequisites to licensing, switching from one professional path to another is difficult, financially and otherwise. The heavy investment of time, energy, and money required in the pursuit of professional training and career ensures a high degree of willingness to 'stay the course' and compliance with the terms of internal competition and stratification. Personal sponsorship, which persists in spite of the alleged standardization of professional training and certification, extends the structural control to the fine points of individual disposition to produce a more complete socialization. (*Ibid.*, pp. 229-230.) Privileged middle class careers depend on the stability of credentialing and employing institutions and, therefore, incline its members toward conformity with the existing social order and its institutions. The expectation of a career binds the projected self to organizations which underwrite the continued viability of a given profession as a source of higher material rewards and social status. Quite apart from ideological socialization, compliance with the terms of internal competition and stratification rests on structural foundations of professional work. In Larson's words, "in pursuing individual mobility, aspiring professionals reinforce the hierarchy of organizations upon which elites found their status and their privileges." Since mature professions are characterized by the relative consensus regarding the fundamentals of the profession's cognitive base and the methods of professional training, certification, and advancement, alternative criteria of professional excellence and personal achievement are typically unavailing. Non-conformance, in this situation, bears heavy costs. In individual terms, "to orient one's professional life outside the [established] system of evaluation and rewards ... is to accept marginality by force or by choice." (*Ibid.*, p. 72.)

inequality. Traditional approaches to the analysis of occupations, organization, and classes – whether of Marxist or Weberian inspiration – paid little attention to the question of structured race and gender inequality, leaving major ‘blind spots’ in our view of social stratification.

The earliest studies of gender in the workplace focused on the problem of the so-called semi-professions of school-teaching, nursing, and social work in which women predominated. According to Etzioni, the editor and contributor to one of the earliest studies, location within the bureaucratic organization and the predominance of women were the defining features of these occupations. The largely female composition of the semi-professions’ membership, he argued, limited the capacity of these occupational groups to achieve the fully professional status. The marginal position of school-teaching, nursing, social work and other typically female occupations stemmed from the low social status of women in general.⁴⁷ Simpson and Simpson concurred that the subordinate position of the semi-professions in the occupational hierarchy was sealed by the attitudes and behaviors of their female membership. “A woman’s primary attachment is to the family role;” argued the authors, “women are therefore less intrinsically committed to work than men and less likely to maintain a high level of specialized knowledge.” Typically sharing “the general cultural norm that women should defer to men,” women were both less able to wield authority and more willing to accept subordination. In short, the semi-professional female workers were willing subordinates, ideally suited to the role of “hand-maidens of a male occupation that has authority over them.”⁴⁸ Etzioni’s overall

⁴⁷ Amitai Etzioni, ed., *The Semi-Professions and Their Organization* (New York: Free Press, 1969).

⁴⁸ R.L. Simpson and I.H. Simpson, “Women and Bureaucracy in the Semi-Professions” in *The Semi-Professions and Their Organization*, ed. A Etzioni (New York: Free Press, 1969), pp. 199, 241, 231.

recommendation for the semi-professions was to renounce their “inauthentic aspirations” to the full professional status.⁴⁹

As with the professions, conventional approaches to the study of modern bureaucratic organizations gave little importance to the fact that the emergence and development of these structures proceeded along unmistakably gendered lines. To be sure, the peculiar patterns of gender segregation within organizational hierarchies have been noted early. In his classic study of the American middle classes, C. Wright Mills, for instance, was quite direct that the basic structure of white-collar bureaucracies is defined by gender and age: younger and feminine at the bottom of the pyramid and older and masculine toward the apex.⁵⁰ Such awareness, however, did not prompt any serious rethinking of the conventional gender-blind theory of bureaucracy inherited from Weber.

A serious interrogation of gender as a structuring principle of inequality had to await the political and academic upheaval of the ‘second wave’ feminism.⁵¹ The feminist scholarship of this period had early and formative encounters with the challenges of race, sexuality, post-colonialism, and class, producing a literature rich in intersecting perspectives on inequality. Multidimensional vision emphasized in the feminist theory posed specific problems as well. For students of stratification, the challenge was to disentangle the effect of gender, on the one hand, and class, power,

⁴⁹ Etzioni, ed., *The Semi-Professions and Their Organization*, pp. vi, vii.

⁵⁰ C. Wright Mills, *White Collar: The American Middle Classes* (New York: Oxford University Press, 1951), p. 75, see also pp. 189-212.

⁵¹ Juliet Mitchell, *Psychoanalysis and Feminism* (Harmondsworth: Penguin, 1975); Zillah R. Eisenstein, ed., *Capitalist Patriarchy and the Case for Socialist Feminism* (New York: Monthly Review Press, 1979); Michele Barrett, *Women’s Oppression Today: Problems in Marxist Feminist Analysis* (London: Verso, 1980); Zillah R. Eisenstein, *The Radical Future of Liberal Feminism* (New York: Longman, 1981); R.W. Connell, *Gender and Power: Society, the Person and Sexual Politics* (Cambridge: Polity Press, 1987); Rosemary Crompton and Kay Sanderson, *Gendered Jobs and Social Change* (London: Unwin Hyman, 1990); Sylvia Walby, *Theorizing Patriarchy* (Oxford: Basil Blackwell, 1990).

and authority, on the other. This effort produced a range of different and even opposed conclusions.

While highly critical of the prevailing “machismo theory of professionalization,” Frank Parkin concluded nevertheless that the focus on the gender composition of an occupation presents “the least promising point of departure” on the road toward understanding the success or failure of professionalization. In his view, the heteronomous nature of the semi-professions – some of which have been “virtually the *creation* of bureaucracy” and all of which are tightly controlled by external bureaucratic organizations – was a more plausible explanation for their failure to achieve full autonomy and other attributes of the ‘real’ professions. The predominantly female composition of these occupations can then be understood as a result of a low appeal, which these bureaucratically controlled occupations hold for men, with the exception of their highest levels of authority.⁵² A similar argument was advanced by Lockwood who argued that “it is the position of an occupation within some hierarchy of authority that is decisive for its status and not the sex of the person who happens to be in it.”⁵³ Both of these arguments, however, confound the individual and the group levels of analysis. Of course, it is the position of the occupation and not the gender of the individual which determines the status of the incumbent.⁵⁴ Gender may indeed not be the best point of departure, as Parkin claimed, but only because the predominant gender of the occupation’s membership must first itself be explained in terms of historical struggles surrounding the construction of that occupational field and its multiple attributes.

⁵² Parkin, *Marxism and Class Theory*, pp. 104-106.

⁵³ David Lockwood, “Class, status and gender” in *Gender and Stratification*, ed. Rosemary Crompton and Michael Mann (Cambridge: Polity Press, 1986), p. 21.

⁵⁴ This applies to incumbents of a predominant gender in highly gendered occupations. In mixed-gender occupations, gender plays a prominent role in determining the typical level of individual professional standing.

Historical and, especially, comparative accounts of the emergence of such gendered professions as nursing and medicine, school-teaching and university-teaching, psychology and psychiatry, to name just a few, clearly demonstrate that the relationship between the status and gender composition of the occupation has been typically one of continual, cyclical interaction. During the second half of the nineteenth century, bourgeois men already had exclusive access to many institutional forms in modern society, like the university, professional associations, and the state which facilitated their monopolization of the higher echelons of professional and bureaucratic hierarchies. While women have engaged in a struggle to directly challenge those barriers which excluded them from entry into the more prestigious, male-dominated professions of medicine, law, etc., in view of the odds, many have chosen to enter occupational fields with lower economic returns and greater external control, than not at all. Effectively barred from entry into the most prestigious professions and organizational posts, women had to struggle for professionalization of other occupational activities. It is through this continual feed-back between occupation's desirability and the gender of its membership that the complex nature of modern occupational structure has been constructed.

This complexity is well captured by Glazer and Slater in their study of women's entrance into the professions in America between 1890 and 1940. While acknowledging that, at the dawn of modern professionalism, middle- and upper-class men had a nearly exclusive access to those institutional forms in modern society (like the university, professional associations, and the state) which facilitated the monopolization of professional and bureaucratic hierarchies, they argue that middle-class women also had distinctive social resources to gain a foothold in professional work, compared with their working-class sisters. Thus, although the movement towards occupational professionalization occurred independently of women's

interests, middle class women seized the emergence of modern professions as a moment of historical opportunity.⁵⁵

An inclination to reduce gender to other factors appeared in Rosabeth Moss Kanter's pioneering study, *Men and Women of the Corporation*, which used the reconstructed Weberian perspective to look at the relationship between gender and organizational power. In reaction to the prevailing behaviorist view of women as willing, 'born-and-raised' subordinates, Kanter argued that power differences, not gender differences, explain the divergent organizational experiences of men and women.

the fate of women is inextricably bound up with organizational structure and processes in the same way that men's life-at-work is shaped by them. Differences based on sex retreat into the background as the people-creating, behavior-shaping properties of organizational locations become clear.⁵⁶

In a manner reminiscent of Parkin's critique of the 'feminine' theory of the semi-professions, Kanter denies that there are any intrinsically different, gendered modes of behavior and orientation that account for the subordinate position of women in organizational hierarchies. What look like innate gender differences, she insists, are really systematic differences of power between male and female occupants of hierarchical organizational positions.

The implication of her analysis is that, should women be able to secure organizational power, their gender would become largely irrelevant. At present, however, not only do men wield widely disproportionate organizational power but they also systematically exclude women from sharing in the sources and practices of power. One of the principal ways in which women are excluded, while men are

⁵⁵ Penina Migdal Glazer and Miriam Slater, *Unequal Colleagues: The Entrance of Women into the Professions, 1890-1940* (New Brunswick and London: Rutgers University Press, 1987).

⁵⁶ Rosabeth Moss Kanter, *Men and Women of the Corporation* (New York: Basic Books, 1977), p. 9.

included, into the circuits of organizational power is through the practices of homosociability among the male superordinates. Since Kanter does not reject the Weberian view of bureaucratic organization as essentially rational, she sees homosociability as a largely rational response to the costs of knowledge and communication. By limiting managerial positions to males, managers avoid the costs of communicating with those (female) others who are substantially unlike themselves and whom they do not as easily understand or 'read.'⁵⁷ A corollary of women's exclusion from sharing in the organizational power is that their inclusion into modern organizations takes the form of subordination to male superiors.

A sharp distinction Kanter draws between gender and power is helpful in that it allows us to see that organizational powerlessness is not limited to individuals of female gender but is a fact of (working) life for men in non- or lower-managerial positions. As a result, Kanter's argument leaves ample space for considering, alongside gender, the effects of class, race and other indices of social inequality and their inter-relationship with organizational hierarchies. At the same time, her insistence that it is *solely* differences in power, rather than gender differences which account for systematic subordination of women within organizations is problematic.

Like Parkin's rejection of gender as an explanatory variable in the study of occupations, Kanter's insistence on analyzing women's organizational position in terms of power rather than gender may be seen as a reaction to behaviorist view of women constructed in post-World War II social science. Nevertheless, the categorical removal of gender as an analytical category is problematic. Gender differences, which render women different and, therefore, more 'costly' to include in predominantly male managerial circles, are constructed both inside and outside of work organizations, both

⁵⁷ *Ibid.*, p. 58.

before and after women enter organizational workplaces. Women enter organizations as already gendered subjects and their intra-organizational subordination is only one link in the web of social relations of inequality in which both gender and organizational authority are only two of several major cleavages. Systematic gender inequality within an organization is not reducible to internal organizational structure or power struggles. It is fed by sources flowing from a terrain more extensive than any particular organizations or even the totality of formal organizations. This is not to say that the structures of gender inequality within organizations simply reflect or reproduce some larger and hidden ur-structure of gender inequality. Nevertheless, both their autonomy and their specificity are clearly relative vis-à-vis the larger socio-historical forces.

If Parkin and Kanter argued that the gender of occupations and organizational positions is a construct of other, more fundamental forces, other scholars conceptualized the relationship between (feminine) gender, on the one hand, and professional privilege and bureaucratic authority, on the other, as one of antinomy. Hearn, for example, has offered a radical redefinition of professionalization as a patriarchal process.⁵⁸ His thesis is premised on the conceptualization of the substance of modern professional practice as functions that have been historically carried out in the private domain by female caregivers. Modern professionalism is then seen as a process whereby men usurp activities that relate to emotional experiences, biological reproduction, and the reproduction of labour power and transfer them to the sphere of public institutions and market exchange. Full professionalization indicates a complete

⁵⁸ Jeff Hearn, "Notes on Patriarchy, Professionalization and the Semi-Professions," *Sociology* 16, no. 2 (1982), pp.184-202.

male dominance of an activity, whereas semi-professional status denotes partial male control.⁵⁹

In *The Feminist Case Against Bureaucracy*, Kathy Ferguson presented a similar argument in regard to bureaucratization. She argued that bureaucratic structure and discourse are fundamentally alien to, and oppressive of, women and urged women to seek alternative organized forms rather than their inclusion within male-inflected bureaucratic organizations. For Ferguson, the male-dominated character of bureaucratic organization stems from the historical experience of men's exclusive access to the public realm where both bureaucratic discourse and its institutional practices have evolved. Women's historical exclusion from the public realm has meant that bureaucratic discourse both expresses and perpetuates women's marginality to the public realm. Limited to the private realm, women, argues Ferguson, have developed a different and a submerged discourse stemming from female-dominated modes of action in the private realm. Appropriately liberated from oppressive, masochistic and self-sacrificial modalities, this discourse can form a foundation for feminist alternative to bureaucratic rationality.⁶⁰

Although Hearn and Ferguson open up the possibility of theorizing professionalization and bureaucratization in relation to patriarchal processes, the manner in which they conflate professional and bureaucratic control with patriarchal power at a definitional level is problematic. If professional and bureaucratic control is defined *as* patriarchal control, and professional and bureaucratic power *as* male power, it is impossible to account for women's entrance into the professions and bureaucratic hierarchies other than as cases of masochism and/or co-optation. It is obvious that

⁵⁹ *Ibid.*, pp. 195-196.

⁶⁰ Kathy E. Ferguson, *The Feminist Case Against Bureaucracy* (Philadelphia: Temple University Press, 1984).

these approaches suffer from inattention to the issues of class and/or internal stratification within male-dominated professions and organizations. Were they to attend to these questions, they would see that oppression and powerlessness apply to the lower rungs of *male* professionals and bureaucrats as well, and that women in the higher rungs of professional and bureaucratic structures are clearly privileged in relation to subordinate workers of either sex.

A combined analysis of class and gender structures provides an important check on essentializing tendencies inherent in each undertaken separately. The pioneering works in this undertaking proposed that the analysis of the relationship between gender and class must proceed from the framework which explores the intersection between two structuring principles, those of patriarchy and those of capitalism.⁶¹ A common thread running through various versions of the dual-systems analysis is the proposal to view class formation as in part based on gendered processes and, concomitantly, the formation of gendered collectivities as linked to class.

An historic formation of the new middle class provides a good illustration of the possibilities, and challenges, of this approach. The 'new middle class' has been variously understood to refer to those relatively advantaged, organizationally based

⁶¹ Juliet Mitchell, *Psychoanalysis and Feminism* (Harmondsworth: Penguin, 1975); Heidi I. Hartmann, "Capitalism, Patriarchy and Job Segregation by Sex" in *Capitalist Patriarchy and the Case for Socialist Feminism*, ed. Zillah R. Eisenstein (New York: Monthly Review Press, 1979); Michele Barrett, *Women's Oppression Today: Problems in Marxist Feminist Analysis* (London: Verso, 1980); Zillah R. Eisenstein, *The Radical Future of Liberal Feminism* (New York: Longman, 1981). It must be noted that, while there is little objection to the use of the concept of patriarchy to describe the organization of power relations between men and women which prevailed until modern times, the use of the term in a more general way to describe the oppression of women is not unproblematic given the transformation of male and female statuses which have taken place over the last two centuries. Despite these formal changes in status, many feminist writers have nevertheless argued that a system of gendered inequality is identifiable today and many continue to use the term 'patriarchy,' appropriately updated, to refer to it. The concept of patriarchy in recent works has been that of a historically specific and variable ensemble of institutions and practices. The common motif is transition from private to public patriarchy and/or the emergence of multiple interrelated structuring fields of gender relations. See, for instance, R.W. Connell, *Gender and Power: Society, the Person and Sexual Politics* (Cambridge: Polity Press, 1987); Rosemary Crompton and Kay Sanderson, *Gendered Jobs and Social Change* (London: Unwin Hyman, 1990); Sylvia Walby, *Theorizing Patriarchy* (Oxford: Basil Blackwell, 1990).

white-collar positions whose incumbents typically function in professional, managerial, and administrative capacities. The unified definition of the 'new middle class,' however, systematically ran into considerable and evolving differences the various categories of white-collar workforce. The main lines of internal differentiation have been frequently specified as those which divide: (1) the higher-level professional and managerial functions, (2) the less prestigious professional and semi-professional occupations and the lower supervisory positions, and (3) the lower-level administrative and service occupations.

The fact that both of these boundaries – between the professional and semi-professional positions and between both of the above and the routine white-collar work – are considerably gendered has not escaped notice of class theorists. Abercrombie and Urry, for instance, stressed both the proletarian and feminized character of routine white-collar work comprising the dual basis of its distinction from the core of the service class. Goldthorpe, too, employed gender to designate the occupational profiles of the class sections.⁶² But what these authors do not sufficiently theorize is the corollary of the feminine character of the routine white-collar positions, namely, the *masculine* character of those managerial, administrative and managerial positions which constitute the core of the so-called service class and the *patriarchal* modes of their construction. Indeed, as Anne Witz argued, existing attempts to specify the structural position and social formation of the new middle class have been significantly constrained by their failure to theorize explicitly their gendered aspect.⁶³

Historically, the bureaucratic career emerged as a gendered, male phenomenon, intimately linked with the 'White Blouse Revolution,' the employment

⁶² Abercrombie and Urry, *Capital, Labour and the New Middle Classes*, pp. 39-40; Goldthorpe, *Social Mobility and the Class Structure in Modern Britain*, 2nd edition.

⁶³ Witz, *Professions and Patriarchy*, p. 205.

of large numbers of women in routine clerical work. During the crucial developmental period of corporate bureaucracies, most organizations had strictly gendered structures, in which women and men were recruited into different grades of employment with different salary scales and promotion prospects. Many organizations imposed marriage bars on their female workers, forcing them to retire on marriage and so to become full-time housewives. The typical male career pattern, characterized by the anticipated and steady upward progression, was thus importantly premised on the fact that much routine work was carried out by women who were practically ineligible for promotion. Women's job 'immobility' substantially enhanced the promotion prospects of junior men.⁶⁴

The idea of the male career has rested on yet another assumption – the existence of a female 'servicer' expected to carry out a range of household, secretarial, and personal duties and so allowing a man to devote more time to his work. As Acker argued, the supposedly gender-neutral places within modern occupational and organizational structures are quite explicitly gendered.

In organizational logic, both jobs and hierarchies are abstract categories that have no occupants, no bodies, no gender. ... [F]illing the abstract job is a disembodied worker who exists only for the work ... The closest the disembodied worker doing the abstract job comes to a real worker is the male worker whose life centers on his fulltime, life-long job, while his wife or another woman takes care of his personal needs and his children. ... The concept of 'a job' is thus implicitly a gendered concept, even though organizational logic presents it as gender neutral. 'A job' already contains the gender-based division of labor and the separation between the public and the

⁶⁴ Rosemary Crompton and Gareth Jones, *A White Collar Proletariat? Deskilling and Gender in Clerical Work* (Basingstoke: Macmillan, 1984); Rosemary Crompton, "Women in the Service Class" in *Gender and Stratification*, ed. Rosemary Crompton and M Mann (Cambridge: Polity Press, 1986); Gregory Anderson, ed., *The White Blouse Revolution* (Manchester: Manchester University Press, 1989). It must be added that the well-entrenched 'immobility' of those lower economic groups we call the working classes and the poor provided an even more basic condition for the new middle class mobility.

private sphere. The concept of 'a job' assumes a particular gendered organization of domestic life and social production.⁶⁵

Thus, both modern corporate and bureaucratic organizations helped define women as both subordinate workers in white-collar hierarchies and dependent marital parties and drew upon it for their competitive advantages.

Segregation of women in the lower rungs of white-collar hierarchies and their confinement to a primary domestic role point toward gendered patterns of location and movement within the overall division of labor. An even stronger interpretation emerging from recent work is that gendered processes account not only for 'staffing,' but for the very creation of work roles. As Rosemary Pringle argued in her study of the secretarial occupation, the very existence of particular jobs is rooted in gender inequality. The job of a secretary, for example, is defined by the types of feminine traits which the female incumbents of these positions are presumed to have. Similarly, Mike Savage argued that the boundary between professional and managerial positions within the structure of middle class employment has been explicitly constituted along gendered lines and that the creation of managerial cadres as a social grouping has been linked to their place in sustaining gendered forms of power.⁶⁶

A common conclusion emerging from these and other arguments is that occupational and organizational structures, as well as the social processes behind them, are gendered. Whether we focus on occupations or on jobs, gendered structures provide key resources in the constitution of the modern division of labor.⁶⁷

Conversely, the modern division of labor is an important sphere in which gender

⁶⁵ Joan Acker, "Hierarchies, Jobs, Bodies: A Theory of Gendered Organizations," *Gender and Society* 4, no. 2 (1990), p. 149.

⁶⁶ Rosemary Pringle, *Secretaries Talk: Sexuality, Power and Work* (London and New York: Verso, 1989); Mike Savage, "Women's Expertise, Men's Authority: Gendered Organizations and the Contemporary Middle Classes" in *Gender and Bureaucracy*, ed. Mike Savage and Anne Witz (Oxford: Blackwell, 1992).

⁶⁷ Witz, *Professions and Patriarchy*, pp. 5, 192.

relations are institutionalized and enacted. A tacit conceptualization of class positions in gendered terms, unsupported by an explicit specification of class-gender interrelationship, implies a failure to appreciate that the distinction between ‘people’ and ‘places’ is untenable. Places are not formed through purely economic processes, as some theorists maintain, but are also shaped by sexist and racist structures and strategies.⁶⁸

Race

As with gender, the classical studies of social inequality were either silent about race or dismissive of its pivotal and enduring significance in modern societies. Although European states were deeply engaged in imperialist conquest and oppressive racialization of the global East and South, the founding fathers of modern social sciences gave scant attention to the race-based inequality and oppression.⁶⁹ The foundations for the systematic engagements with race and racism were laid by intellectuals from the oppressed groups engaged in the struggles against racism, colonialism, and anti-Semitism.⁷⁰ While social scientists generally rejected biological

⁶⁸ The distinction between ‘places’ and ‘people’ in conjunction with theorizing the relationship between class and gender was originally formulated by Hartmann (1979) who proposed that capitalist processes specify the structure of class positions, while patriarchal and racist dynamics determine who fills them. This position has been subsequently heavily criticized and, for the most part, abandoned in the feminist literature concerned with the intersection of class and gender processes. However, this distinction between ‘places’ and ‘people’ survives both within certain orientations in class analysis and their treatment, if any, of the relationship between class and gender. See, for example, Wright, *Class Counts* and John H. Goldthorpe with Catriona Llewellyn and Clive Paine, *Social Mobility and the Class Structure in Modern Britain*, 2nd edition (Oxford University Press, 1987).

⁶⁹ Walter R. Allen and Angue Y. Chung, “‘Your Blues Ain’t Like My Blues’: Race, Ethnicity, and Social Inequality in America,” *Contemporary Sociology*, Vol. 29, No. 6 (November 2000), pp. 796-805; Howard Winant, “Race and Race Theory,” *Annual Review of Sociology*, Vol. 26 (2000), pp. 169-185.

⁷⁰ W.E.B. DuBois, *Black Reconstruction in the United States: An Essay Toward a History of the Part Which Black Folk Played in the Attempt to Reconstruct Democracy in America, 1860-1880* (New York: Atheneum, 1977 [1935]), *The Suppression of the Slave-Trade to the United States of America 1638-1870* (New York: Dover, 1970 [1896]), and *The Philadelphia Negro* (Philadelphia: The University of Pennsylvania Press, 1996 [1899]), *The Souls of Black Folk* (New York: Penguin, 1989 [1903]); *Dusk of Dawn: An Essay Toward an Autobiography of a Race Concept* (New Brunswick, NJ: Transaction, 1991 [1940]); Frantz Fanon, *The Wretched of the Earth*, trans. Richard Philcox (New York: Grove Press, 2004), *Black Skin, White Masks*, trans. Charles Lam Markmann (London: Pluto Press, 1986); Magnus Hirschfeld, *Racism*, trans. Eden and Cedar Paul (Port Washington, NY: Kennikat Press, 1973). On the

notions of race in favor of sociohistorical conceptions of racialization, their theories were not immune from subtler influences of racist ideologies. Many conceptualizations of race and racism tended toward idealism and/or reductionism. A widespread approach to understanding racism defined it as a dogmatic set of beliefs about racial superiority or inferiority, thus situating the problem of race primarily in the realm of culture and ideology.⁷¹ Early sociological approaches viewed racial inequality as a variant ethnic difference, predicting a progressive process of accommodation and assimilation.⁷² Marxist and neo-Marxist scholars tended to subsume the question of race and racism under the problematic of class and capitalism, seeing racial inequality as either the legitimating ideology or the structural device of exploitation.⁷³ The internal colonialism perspective equated the problem of racism with that of nationhood and colonialism.⁷⁴ The idealist and reductive tendencies within earlier race theory have been increasingly criticized by those who favor more structural and historically specific accounts of racial inequality.

minimal early contribution of American political science to the study of race, see Rogers M. Smith, "The Puzzling Place of Race in American Political Science," *PS: Perspectives on Politics*, Vol. 37, No. 1 (January 2004), pp 41-45.

⁷¹ Ruth F. Benedict, *Race and Racism* (London: Routledge and Kegan Paul, 1945); Pierre van den Berghe, *Race and Racism: A Comparative Perspective* (New York: John Wiley and Sons, 1967).

⁷² Robert E. Park, *Race and Culture* (Glencoe, IL: Free Press, 1950); Gunnar Myrdal, *An American Dilemma: The Negro Problem and Modern Democracy* (New York: Harper and Brothers, 1944); Edward B. Reuter, ed., *Race and Culture Contact* (New York: McGraw Hill, 1934).

⁷³ Oliver C. Cox, *Caste, Class, and Race* (New York, Doubleday, 1948); Victor Perlo, *Economics of Racism U.S.A.: Roots of Black Inequality* (New York: International Publishers, 1975); Albert Szymanski, "The Political Economy of Racism" in *Political Economy: A Critique of American Society*, ed. S. G. McNall (Dallas, TX: Scott Foresman, 1981); Edna Bonacich, "A Theory of Ethnic Antagonism: The Split Labor Market," *American Sociological Review* (October 1972), pp. 547-59 and "Advanced Capitalism and Black/White Relations in the United States: A Split Labor Market Interpretation" in *The Sociology of Race Relations: Reflection and Reform*, ed. T. Pettigrew (New York: Free Press, 1980); Guglielmo Carchedi, *Class Analysis and Social Research* (Oxford: Basil Blackwell, 1987).

⁷⁴ Mario Barrera, *Race and Class in the Southwest: A Theory of Racial Inequality* (Notre Dame, IL: University of Notre Dame Press, 1979); Robert Blauner, *Racial Oppression in America* (New York: Harper and Row, 1972); Joan W. Moore, "Colonialism: The Case of Mexican-Americans," *Social Problems* 17:463-72.

Contemporary debate on race has been grappling with the structural and cultural transformations which occurred since the Civil Rights era. The end of the legalized forms of racial segregation and discrimination, the emergence of the black middle class, and the growing presence and notable successes of other minority groups coincided with continuing poverty, residential segregation, mass imprisonment, and racial backlash against African-Americans and other racialized minorities. One of the prominent issues of contention in recent decades has been the question of the comparative significance of race and class in contemporary American society. One side of this debate, most closely associated with the work of William Julius Wilson, argues that economic and class restructuring resulted in a declining importance of race in contemporary American society.⁷⁵ In *The Declining Significance of Race* and *The Truly Disadvantaged*, Wilson argued that during the period after World War II the importance of race in determining social position has been eclipsed by the growing consolidation of class divisions in the economic sector. The force of the Civil Rights movement compelled the American state to dismantle the discriminatory laws. These achievements, however, mainly helped the African-American middle-class, while doing little to improve the deteriorating conditions of the growing black underclass. According to Wilson, the life chances of African-Americans are no longer primarily determined by race, but by economic class.

Their opponents, exemplified by Michael Omi and Howard Winant, counter that recent changes have only reconstructed racial meanings and divisions, while also spurring a rise in racial tensions.⁷⁶ The continuing significance of race can be

⁷⁵ William Julius Wilson, *The Declining Significance of Race* (Chicago: University of Chicago Press, 1980), *The Truly Disadvantaged* (Chicago: University of Chicago Press, 1987), and *When Work Disappears: The World of the New Urban Poor* (New York: Alfred A. Knopf, 1996).

⁷⁶ Michael Omi and Howard Winant, *Racial Formation in the United States*, 2nd ed. (New York: Routledge, 1994).

discerned in specific forms of racially charged attacks on welfare, affirmative action, and urban development. With the elimination of legal racial barriers, the neo-conservative forces in American politics have used the notions of colorblind society and reverse discrimination to block legislation aimed at improving the socio-economic position of minority populations. This backlash took the form of cutbacks in welfare, affirmative action, education, health care, and other crucial programs.⁷⁷ In this view, race continues to have an enormous significance in the United States.

Whether one agrees with Wilson's findings or not, one thing is clear: the logic and mechanisms of racialization must be more clearly specified and distinguished from other structuring mechanisms.⁷⁸ The 'racial formation' perspective advanced by Omi and Winant, as well as the 'racialized social systems' thesis formulated by Bonilla-Silva, present some of the most promising efforts in this direction.⁷⁹ Omi and Winant define racial formation as "the sociohistorical process by which racial categories are created, inhabited, transformed and destroyed."⁸⁰ In societies characterized by racial formation, race is an organizing principle of social

⁷⁷ Lawrence Bobo and Ryan A. Smith, "From Jim Crow Racism to Laissez-Faire Racism: An Essay on the Transformation of Racial Attitudes in America" in *Beyond Pluralism: The Conception of Groups and Group Identities in America*, ed. Wendy Katkin and Andrea Tyree (Urbana: University of Illinois Press, 1998); Philip Klinkner, *The Unsteady March: The Rise and Decline of Racial Equality in America* (Chicago: University of Chicago Press, 1999); Walter R. Allen and Joseph O. Jewell, "African-American Education Since 'An American Dilemma': An American Dilemma Revisited," *Daedalus* 124 (1995), pp. 77-100; Dalton Conley, *Being Black, Living in the Red: Race, Wealth, and Social Policy in America* (Berkeley: University of California Press, 1999); Joe R. Feagin, "The Continuing Significance of Race: Antiblack Discrimination in Public Places," *American Sociological Review* 56 (1991), pp. 101-16; Douglas Massey, "American Apartheid: Segregation and the Making of the Underclass," *American Journal of Sociology* 96 (1990), pp. 329-57; Joe R. Feagin and Melvin P. Sikes, *Living with Racism: The Black Middle-Class Experience* (Boston: Beacon Press, 1995); Mary Patillo-McCoy, *Black Picket Fences: Privilege and Peril Among the Black Middle Class* (Chicago: University of Chicago Press, 1999); Melvin L. Oliver and Thomas M. Shapiro, *Black Wealth/White Wealth: A New Perspective on Racial Inequality* (New York: Routledge, 1995).

⁷⁸ Jack Niemonen, *Race, Class, and the State in Contemporary Sociology: The William Julius Wilson Debates* (Boulder, CO: Lynne Rienner Publishers, 2002).

⁷⁹ Omi and Winant, *Racial Formation in the United States*; Eduardo Bonilla-Silva, "Rethinking Racism: Toward a Structural Interpretation," *American Sociological Review* Vol. 62, No. 3 (June 1997), pp. 465-480.

⁸⁰ Omi and Winant, *Racial Formation in the United States*, p. 55.

relationships that operates both at micro and macro levels of social structuring. 'Race' shapes both the individual identities and all spheres of social life.

Bonilla-Silva defines racialized social systems as "societies in which economic, political, social, and ideological levels are partially structured by the placement of actors in racial categories or races."⁸¹ In these societies, both material and symbolic rewards are distributed in part along racial lines. Racial structures are always hierarchical, with racial groups receiving different social and symbolic rewards at all levels. The particular character of hierarchy and its elements is varies across time and space. In general, however, "the more dissimilar the races' life chances, the more racialized the social system."⁸²

For Omi and Winant, 'races' are the outcome of the racialization process, which they define as "the extension of racial meanings to a previously racially unclassified relationships, social practice or group."⁸³ The construction of racial categories involves defining both 'otherness' and 'sameness,' as well as hierarchical ordering of their attributes. Historically, the classification of groups in racial terms has been a highly political act associated with conquest, colonization, and enslavement. Racialization may have initially stemmed from the interests of the political and economic elites, but once established they benefit all the members of the dominant race. Although racialization is socially constructed, social relations between races become institutionalized at the level of structure as well as culture. Racial ideologies, which emerge in racialized societies, are as real in their effects as racial relations they help reproduce.

⁸¹ Bonilla-Silva, "Rethinking Racism," p. 469.

⁸² Bonilla-Silva, "Rethinking Racism," p. 471.

⁸³ Omi and Winant, *Racial Formation in the United States*, p. 64.

What about other dimensions of inequality? Racialization of social systems did not imply the displacement of other forms of oppression. To the contrary, racialization occurred in social formations also structured by class and gender. Hence, racial formations are intersected by other dimensions of inequality. Which dimensions of inequality will be more salient is historically contingent and cannot be determined a priori.⁸⁴ In a multidimensional social structure, racialized actors are also ‘classed’ and ‘gendered.’ Conversely, both gender and class categories are racialized and the struggles based on gender and class differences typically include a racial component. Thus, racialization exerts independent effect within the framework of multiple structuration.

Institutional Class Positions

In a recent article, Leslie McCall has offered a useful classification of ‘intersectional’ approaches according to their stance toward categories of social difference and inequality, as shown in Table 2.1.

Table 2.1. *Three Approaches to Categories within the Intersectionality Paradigm*

Inter-Categorical Complexity	Intra-Categorical Complexity	Anti-Categorical Complexity
Requires that scholars provisionally adopt existing analytical categories to document relationships of inequality among social groups and changing configurations of inequality along multiple and conflicting dimensions.	Maintains a critical stance toward categories and interrogates the boundary-making and boundary-defining process itself, while acknowledging the stable and even durable relationships that social categories represent at any given point in time.	Based on a methodology that deconstructs analytical categories. Considers social life too irreducibly complex to make fixed categories anything but simplifying social fictions that produce inequalities in the process of producing differences.

Source: Leslie McCall, “The Complexity of Intersectionality,” *Signs*, Vol. 30, No. 3 (Spring 2005), pp. 1771-1800.

⁸⁴ Bonilla-Silva, “Rethinking Racism,” p. 471.

McCall points out that the type of intersectional approach adopted may stem not only from philosophical and epistemological considerations but also from the choice of method and question under investigation. The approach adopted in this dissertation lies somewhere in-between and outside of this classification. Like practitioners of the inter-categorical approach I have provisionally adopted the five ‘existing’ categories of analysis at the beginning of my research. As I delved further into my investigation, the need to search for a newer and less established conceptualization of social division became quite pressing. The reason why my approach cannot be squarely identified either within or between the three frameworks distinguished by McCall is because she differentiates approaches on the basis of their stance toward conventional and, I may add, ‘macro’ categories of social division. Implicit in all intersectional work, however, is the existence of ‘micro’ categories of social division and a different way to classify intersectional work may be in accordance with their conceptualization and stance toward these smaller and new categories of analysis.

One thing that is clear is that the great diversity among the studies of intersectionality suggests that ‘intersectional’ frameworks can and must be tailored to the conceptual needs of the topic and method. For the purpose of the present project – which is concerned with institutional politics of the academic medical centers – five dimensions of inequality are of central importance. They are: (1) class, (2) gender, (3) race, (4) occupational divisions, and (5) organizational hierarchies. This is not an exhaustive list of differences structuring the many areas in the health care field but the minimal set of specifications necessary to understand the historical material investigated in this dissertation. My research shows that organizational politics are frequently articulated and structured in terms of divisions, interests, and strategies

lying at the intersection of class, gender, racial, occupational and organizational dimensions of difference. While contingent and malleable, groups and interests that emerge at these intersections are not only quite meaningful to the actors, but also grounded in institutions and organizations which cross-cut the field of academic medicine.

In this dissertation I will use the term ‘institutional class positions’ to denote those varied and contingent positions emerging at the intersection of all or most of these five dimensions. The justification for this move is twofold. On the one hand, the term serves as a convenient short-hand that minimizes the repetitive use of ‘class, race, gender, occupation and organization’ line. On the other hand, it expresses the felt need for new terminology to refer to those multi-dimensional identities and structures that are suggested by the theory of intersectionality. While naming and categorization are not unproblematic practices, the very term ‘intersectionality,’ as well as several related concepts such as ‘complex inequality,’ ‘multiple oppressions’ or ‘hybrid identities,’ are just such exercises in naming the new conceptual terrain.

Why ‘institutional *class* positions’? First, the concept of class has come under especially strong attack and is therefore in need of reinforcement. Second, because of the recent attacks, defenses and rearticulations, class stands as the least entrenched and the most flexible concept. It is not inconceivable that at this moment in history ‘class’ may emerge as the ultimate ‘empty space,’ ready to be imbued with new meanings commensurate with the contemporary structures of social stratification.

CHAPTER 3

BETWEEN THE UNIVERSITY AND THE MARKET: THE 'FULL-TIME' STRUGGLE, 1910-1926

Introduction

Early sociology of the professions defined its object of study as antithetical, in several important aspects, to both classes and institutions.¹ More recent scholarship criticized this view as closely aligned with the professions' own ideological self-presentation.² Nevertheless, the old position persists in more subtle ways in new work, while theoretical analyses linking professions, institutions, and classes remain fragmented and few. Similar challenges face social scientists studying the other two elements of the triad. Class theory, whether of Marxist or Weberian inspiration, has had notable difficulties with integrating the phenomenon of the professions and institutions within which they work into a coherent theoretical framework. The notable absence of class from the analytical arsenal of the institutionalist school of political science testifies to the ideological and cognitive obstacles to theorizing links between institutions, classes, and professions.

Given the limited scope of this study it would be presumptuous to attempt to remedy this situation. Nevertheless, the records documenting the role of the medical profession in the history of the Columbia-Presbyterian Medical Center provide a rich

¹ Talcott Parsons, *The Structure of Social Action* (New York: Free Press, 1949); C. W. Mills, *White Collar: The American Middle Classes* (New York: Oxford University Press, 1951); R. K. Merton, "Bureaucratic Structure and Personality" in Amitai Etzioni, ed., *Industrial Man* (London: Penguin, 1961).

² Terence Johnson, *Professions and Power* (London: Macmillan, 1972) and "The Professions in the Class Structure" in Richard Scase, ed., *Industrial Society: Class, Cleavage and Control* (New York: St. Martin's Press, 1977); Magali Sarfatti Larson, *The Rise of Professionalism: A Sociological Analysis* (Berkeley: University of California Press, 1977); Eliot Friedson, *Professional Powers* (Chicago: University of Chicago Press, 1986); Rosemary Crompton, "Professions in the Current Context," *Work, Employment, and Society* 4 (1990): 147-166.

source of hypotheses regarding the links among the professions, institutions, and classes. Particularly interesting in this regard is a conflict which unfolded around the so-called ‘full-time’ organization of the clinical departments and nearly derailed the entire project of the joint university medical center.

The issue, which serves as a focus of this chapter, concerned the position of the joint professional and academic staffs within the new organizational matrix of the university medical center. As early as the 1870s, those who wished to reorganize American medicine on a scientific foundation stressed the need to make medical research and teaching – whether separately or in combination – into viable occupations freed from the demands and distractions of private practice. An important first step toward this end was the establishment of the full-time teaching and research positions in the basic medical sciences of anatomy, bacteriology, pathology, and physiology.³

These new positions differed from the traditional form of professional practice in two important ways. First, the occupants of these new positions did not sell their services directly to consumers, be they patients or students. Rather, their teaching and research services were contracted by an intermediary institution and compensated from general university funds, consisting of student tuition and other, mostly philanthropic, financial support. Thus, income of the full-time university physicians, which took the form of a university salary, was determined by the financial means and competitive standing of the appointing university or medical school. Second, the various resources required for the professional work of the full-time professors – their ‘means of production’ – were owned by two institutions: the university and the

³ This group of disciplines and the corresponding departments in the medical schools have been variously termed ‘basic science,’ ‘laboratory,’ ‘non-clinical,’ and ‘pre-clinical.’ The first three terms will be used here interchangeably to avoid repetition.

teaching hospital. As a result, the physician-scientist was structurally dependent on institutions and resources external to both the individual researchers and the medical profession as a whole.

There was a considerable variation in ‘full-time’ salaries among the medical schools and geographical regions. Overall, however, they were considerably lower than the private practice income derived by physicians of comparable professional standing or academic rank. This state of things confirmed the widespread belief among physicians that, in addition to limiting their professional autonomy, any form of institutional employment would inevitably depress professional incomes. Like other small entrepreneurs, American physicians felt threatened by the rapid growth of large organizations that began in earnest during the second half of the 19th century, signaling an economic transition from competitive to monopoly capitalism. At the same time, the rise of corporate society also created new opportunities to raise the status of American medicine and the leaders of the profession adopted a proactive strategy of managing professional fortunes in the changing social order. Stronger, more centralized professional organizations succeeded in establishing higher educational standards and thus limiting the number of practitioners. The profession had also accepted the need to locate some elements of its practice within the framework of large institutions, most notably the university and the hospital. The rise of the full-time university positions represented one such concession of the ‘free’ profession to the imperative of the new corporate order.

The organizational and scientific revolutions which transformed Western medicine during the second half of the 19th century also greatly increased its value to society. When the impact of these changes was finally fully felt on this side of the Atlantic, many influential segments of American public felt that the profession’s internal reforms fell far short of optimizing medicine’s social utility. Some reformers,

particularly those outside of the medical profession, believed that the institution of private practice – which allowed physicians to transact their services directly with patients and to set their own fees – confined medicine’s benefits to the well-to-do. It also diverted too much of professional talent away from the main promise of scientific medicine which lay in discovery and prevention of the fundamental causes of disease. One of the crucial steps in limiting what they saw as excessive ‘commercialism’ of the medical profession was to restrict or outright eliminate private practice among the medical school faculty by requiring them to serve on a full-time basis.

This goal became the central policy of the two most powerful philanthropies – the Rockefeller and Carnegie foundations – which chose medicine as a key area of investment. Armed with millions of dollars, the foundations’ managers began to offer large grants to selected medical schools on the condition that they organize all of their departments – clinical as well as basic science – on a full-time basis. While basic science departments had already been so organized at most leading institutions, reorganization of clinical departments presented significant challenges. At that time, clinical professors operated on a traditional basis, devoting only part of their time to teaching and research. The full-time proposal meant that they would have to choose either their academic posts or their often very lucrative private practices.

The implementation of the foundations’ program proved difficult and there was much resistance at each institution which was invited to apply for the grants, as well as from the organized profession. One of the pivotal episodes in the struggle to impose ‘full-time’ requirement on all university physicians took place at Columbia. The University badly needed the money to pay for its part of construction of the joint medical center but its clinical faculty vehemently opposed restrictions on their private practice. So high were the stakes in this fight that it delayed the creation of the Medical Center by some thirteen years. Far more importantly, the outcome of the

struggle which unfolded around Columbia-Presbyterian had far-reaching consequences for American medicine as a whole.

A close inquiry into this episode in the history of American academic medicine yields several insights into the dynamic that has structured important features of the American health care system. Contrary to several authoritative accounts of this period, the lines of conflict in this crucial struggle did not correspond to professional and institutional boundaries but instead cut across both of them. Distinct positions that emerged during the ‘full-time’ dispute corresponded most closely to class and class-fractional divisions common to the middle social strata as a whole, rather than specific to particular institutional or professional enclaves. However, both institutions and the professions played an integral part in defining material interests and providing ideological strategies available to the class and class-fractional groups involved in the conflict. The main lines of cleavage paralleled the different levels of institutional dependence and integration characterizing the position of the various parties to the conflict. While all of the combatants endeavored to frame their positions in broad professional terms, they reached for different elements of professional ideology. At least three distinct ideological stances appeared in the context of the ‘full-time’ conflict and their adoption by the different parties to the struggle closely correlated with the degree of their occupational institutionalization. In sum, institutional organization constituted the very essence of the class groups involved in the struggle, while professional discourses furnished their ideological instruments.

The Reform of American Medicine and the Full-Time Plan

On December 13, 1910, a prominent New York philanthropist, Edward S. Harkness, offered Presbyterian Hospital \$1.3 million dollars if it agreed to affiliate with Columbia University’s Medical School in order that both institutions might rise to new heights of excellence in medical care, education, and research. With the

agreement of affiliation secured in the spring of 1911, the newly affiliated institutions faced two main challenges. The first was to create a geographical union which meant, in effect, that both institutions had to be rebuilt on a common site. The second challenge was to reorganize the staffs of the two institutions along the lines stipulated in the Harkness' offer and the agreement of affiliation. Seemingly distinct, these two issues became tightly intertwined in the process of creating the joint medical center and delayed its realization for over a decade.

Although neither the Harkness' proposal, nor the subsequent agreement between Columbia and Presbyterian defined the terms under which the jointly appointed staff may engage in private practice of medicine, the affiliation was deeply enmeshed in a larger movement to reform American medical education and, through it, medicine as a whole. Harkness' proposal to Presbyterian came less than a year after the publication of the famous "Flexner Report" on the state of American medical education. The Report was secretly solicited by the reform-minded figures in the American Medical Association (AMA) who approached the Carnegie Foundation for the Advancement of Teaching about the matter in 1907.⁴ Actually, the Association was perfectly well informed about the state of American medical education, since only one year earlier its Council on Medical Education inspected and rated every one of the country's 160 or so medical schools. What was sought, then, was not a confirmation of what the Council already knew but the Carnegie Foundation's image of disinterestedness and objectivity, as well as its potential to increase and direct philanthropic investment in medical education. The president of the Carnegie Foundation, Henry S. Pritchett, decided that appointing a layman, rather than a physician to conduct the study would lend more credibility to its findings. This

⁴ E. Richard Brown, *Rockefeller Medicine Men: Medicine and Capitalism in America* (Berkeley: University of California Press, 1979), pp. 151-152.

decision meshed well with the Foundation's view that professional schools ought to be better integrated into a broader system of secondary and higher education. The Foundation found their man in Abraham Flexner, a professional educator recommended to Pritchett by his brother, Dr. Simon Flexner, Director of the Rockefeller Institute for Medical Research. To prepare for the study, Abraham Flexner read up on the history of medical education and went over the AMA's own report on medical schools which he found reliable but rather cautious.⁵ He also visited his alma mater, the Johns Hopkins University, and met with the medical school's leading faculty. At the time, no other medical school expressed the new ideals of scientific medicine better than Hopkins and Flexner came away convinced that it represented a true standard of excellence against which all other medical schools should be judged.

Over a year and half Flexner visited all one hundred fifty-five medical schools in the United States and Canada and produced an unsparingly critical report. His overall conclusion was very much in agreement with the arguments that the leading medical reformers had advanced for several decades. "The country needs fewer and better doctors," Flexner concluded, and "the way to get them better is to produce fewer."⁶ Excessive number and poor training of American physicians were primarily due to overabundance of small 'commercial' medical schools. Supported almost exclusively by the student fees, these schools were run for the sole benefit of their faculties, argued Flexner, and lacked even the most basic resources necessary for scientific education of the future practitioners. Many in the medical profession recognized the need to restrict the number of medical graduates but as long as the

⁵ Brown, p. 145.

⁶ Abraham Flexner, *Medical Education in the United States and Canada, Bulletin Number 4*, (New York: Carnegie Foundation for the Advancement of Teaching, 1910).

quality of medical education was largely unregulated, the temptation to derive the benefits of the proprietary medical education was hard for the individual doctors to resist.

Proliferation of commercial medical schools drove both standards and tuition fees down, allowing lower-middle class and even some ambitious working class youths to acquire medical education. Flexner reported that the schools were overrun by the “mass of unprepared youth ... drawn out of industrial occupations into the study of medicine” and insisted that medical profession should be reserved for those who could afford “a liberal and disinterested education experience.”⁷ Flexner’s overall recommendations were drastic: the first-tier schools should be strengthened and reorganized on the Johns Hopkins model, a few of the second-tier schools should be raised to the same high standard, and the rest disbanded. Out of the one hundred thirty one American schools then in existence, he recommended preserving only thirty one.⁸ Although Flexner was certainly not a puppet of the AMA, the main lines of his argument were surprisingly similar to the reform agenda of the profession’s leaders, or so it seemed shortly after its publication. Medical elites have long argued that the number of doctors should be restricted if the individual members expected to make comfortable living from their chosen profession. Purging the profession of the lower class elements to elevate its prestige was also a sentiment of the professional elite that much predated the Report. Nevertheless, both Flexner and his foundation sponsors had a broader aim than did the leaders of the medical profession. The reform of medicine, as they saw it, was part of the larger process of social and economic rationalization which had arisen in response to the excesses of unrestricted competition.⁹ Its main

⁷ Brown, p. 148.

⁸ Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982), p. 121.

⁹ Larson, *The Rise of Professionalism*, p. 163.

goal, thus, was to restructure medical education, research, and care in accordance with the principles of scientific method and corporate organization. Reducing the number of medical schools was not an end in itself but a precondition for efficient use of resources that had to be invested if the quality of American medicine was to be raised. The capital investment and operating support necessary to raise American medical education to the European standards would have to come from external sources but as long as medical education continued to be organized on a proprietary basis, such support was both unlikely and unwise.

The leaders of the medical profession were aware that the costs of scientific medical education – which required laboratories, hospital affiliations, and salaried science faculty – were beyond the means of potential students and the medical profession. States might be persuaded to increase their support of the state medical schools, but most schools were private institutions and for their support the medical profession had to look to the wealthy. Medical reformers were aware of the danger that external funding might pose and argued that private philanthropic giving should be carefully directed by the profession itself. In this, the AMA leaders considered the “Flexner Report” of great value. So effective was the Report in fostering their aims that the AMA reformers hardly paused at Flexner’s assertion that “[t]he medical profession is an organ differentiated by society for its own highest purposes, not a business to be exploited by individuals according to their own fancy.”¹⁰ For the moment they were elated that medicine was finally becoming recognized as a vital societal function. It was not too long, however, before the conflict between the ultimate aims of the medical profession and the corporate philanthropy would come to light.

¹⁰ Flexner, *Medical Education*.

After the publication of the Flexner's study in 1910, Carnegie Foundation found itself the object of more criticism than it had expected. While the Carnegie Foundation was defending itself from various attacks by the adversely affected physicians, two Rockefeller philanthropies – the General Education Board and the Rockefeller Foundation – were formulating their own strategy of involvement in medical reform. In the spring of 1911, the key figure behind the Rockefeller philanthropies, Frederick T. Gates, invited Abraham Flexner to have a lunch with him. After complimenting Flexner on his Report, Gates casually asked what he would do if he had one million dollars to invest in improvement of American medical education. Without the slightest hesitation, Flexner replied that he would give it all to Johns Hopkins medical school. This was precisely what Gates wanted to hear and he asked if Flexner would go to Baltimore on behalf of the Rockefeller philanthropies to explore the possibility of giving Johns Hopkins a grant of one million dollars.¹¹

The choice of the first recipient of the Rockefeller grant was not accidental, for, if there was one institution which served as a cradle of modern American medicine, Johns Hopkins would be it. The University was founded in 1893 with the \$7 million which the wealthy Baltimore merchant, Johns Hopkins, left in his will to build a hospital and a university. The serendipitous union between the university and the hospital dictated by their founder's will augured well for the success of its medical faculty and the leaders of the university seized an opportunity to create in Baltimore a center of medical research and teaching modeled after the leading European institutions. In a radical departure from prevailing practice, the School established full-time salaried positions in basic sciences of anatomy, physiology, pathology, and pharmacology, the first positions of this kind in America. A traditional professor of

¹¹ Brown, p. 156.

medicine who devoted only part of his time to teaching earned most of his income from private practice and in the end-of-the-century Baltimore could count on making about \$10,000 a year, while the salary for the new full-time positions at Hopkins was set at \$3,000 to \$4,000. For Baltimore's prominent physicians this was a bad bargain but for the aspiring young researchers recruited from far and wide this was a unique opportunity to escape the mundane business of house-calls and devote themselves to science.

William Henry Welch was one such man. After graduating from Yale, Welch wanted to be a tutor in Greek but, seeing few employment prospects, he reluctantly followed his father into medicine. To his own surprise, Welch was soon completely enamored of his new field but what sparked his interest was laboratories and dissecting rooms, not bedside practice. After post-graduate study in Europe, Welch landed in New York's Bellevue Hospital where he established the first pathological laboratory in America. Soon afterward he was invited by president Gilman to become one of the first full-time professors at Johns Hopkins and went on to become the dean of the medical school and one of the most influential figures in American medicine.

Having accepted Gates' assignment, Flexner promptly arranged a meeting with Dr. Welch and two other prominent members of Hopkins faculty, Drs. Franklin P. Mall and William S. Halsted. Mall, who headed the department of anatomy and represented, in effect, the basic science faculty, dominated the meeting. "If the school could get a sum of approximately \$1 million," he proclaimed, "there is only one thing that we ought to do with it – use every penny of its income for the purpose of placing upon a salary basis the heads and assistants in the leading clinical departments." That, Mall added, "is the great reform which needs now to be carried through."¹² Like

¹² Brown, pp. 156-157.

many among the first generation of American medical researchers, Mall strongly believed that medicine should be a science devoted to discovery of biological causes of disease rather than an art of bedside hand-holding and feeble therapies. Mall saw the question of full-time appointments in broad ideological terms. The medical profession, he insisted, had to decide “which ‘G’ to worship – Gold or Glory.” Encouraged by Flexner’s visit, he concluded that “the day of reckoning [was] at hand.”¹³ Like many of his colleagues in the science departments, Mall resented the disparities in the rewards that society bestowed upon those who labored to fight disease at its source and those who attended on the wealthy patients. For Mall, placing the clinical professors on the full-time basis would accomplish two things. First, it would equalize the material interests and institutional loyalty of all medical faculty. Second, it would ensure maximum progress in the advancement of medical science. Mall’s ideas formed the core of Flexner’s report to the Rockefeller foundations and Gates communicated to Welch that, if he could persuade his faculty to institute full-time appointments in all departments, a grant of \$1.5 million was assured.

The laboratory faculty at Johns Hopkins was unanimous in its backing of the plan but the clinical faculty was split. Quite unexpectedly, Dr. Lewellys Barker, who was one of the earliest proponents of the full-time plan, now stood in the way of its implementation at Hopkins refusing to give up his lucrative practice. Eventually, he was convinced to resign his professorship and become a “clinical professor” drawing small salary for his teaching but being able to spend most of his time in private practice. To replace him the university lured Dr. Theodore Janeway away from his chairmanship of surgery at Columbia and his lucrative New York practice. In the fall of 1913 Dean Welch finally had the support of the majority of the clinical professors

¹³ Brown, p. 160.

and Johns Hopkins became the first medical school organized entirely on the full-time principle.

As the news of the Hopkins plan spread, the wave of outrage among the practicing physicians swelled and the AMA joined their side. Driving the attacks was the realization that, if the Hopkins model spread, faculty appointments would no longer be a way to build lucrative private practice. More importantly for the Association, the ‘full-time’ plan threatened to separate the medical faculty from the rest of the profession and transfer their loyalties to the universities. Much of the rhetoric was, of course, couched in loftier terms. Many prominent members of the clinical departments argued that the full-time system would ruin medicine as a caring profession. Dr. William Osler, the renowned professor of medicine who taught at Hopkins until 1904, claimed that without private practice physicians would lose touch with the real practice of medicine and present poor examples for their students. Actually, the full-time plan did not mean that clinical professors would stop bedside practice but only that it would be restricted to the patients of the hospital affiliated with the medical school. What the clinical faculty really stood to lose was contact with the upper- and middle-class patients. To his credit, Janeway, who became dissatisfied with full-time after a while, was more honest on this issue. Resigning his position in 1917, he wrote a widely publicized article admitting that, among other things, his disillusionment stemmed from the fact that he and his family were used to a higher standard of living than his full-time salary allowed.

The all too obvious economic motivations of the concerted attacks on the full-time plan only confirmed to the Rockefeller foundations the dangerous extent of commercialism in the medical profession and the need to uproot it. “This practice of fixing his own price granted to American physicians by custom,” Gates wrote to the other foundation trustees, “is the greatest present American obstruction to the

usefulness of the science of medicine. For it confines the benefits of the science too largely to the rich, when it is the rightful inheritance of all the people alike, and the public health requires they have it.”¹⁴ The profession’s pecuniary interests not only tended to deprive the poor of adequate medical care but also favored treatment, rather than prevention of disease. The problem, of course, went beyond the physician. Individual patients summoned a physician only when already sick and paid for curative rather than preventive measures. Both medical research and prevention were public goods and even the large units of social and economic organization, such as corporations or state governments, were likely to underinvest in them. Like many leading philanthropic managers of his generation, Gates insisted from the beginning of his career to its end that “the fundamental aim of medical science ought to be not primarily the cure but primarily the prevention of disease.” He firmly believed that during the first quarter of the 20th century “sanitary science and preventive medicine” reduced sickness by half, citing support from census mortality rates, insurance industry statistics, and state and local health boards.¹⁵ If medicine was to fulfill its preventive mission, however, economic interests and incentives which structured it had to be thoroughly reorganized.

Rockefeller philanthropies, as well as other large foundations, viewed the ‘full-time’ plan as a centerpiece of their strategy to subordinate the medical profession to the needs of industrial society. Traditionally individual and therapeutic, physician’s function in society had to be made social and preventive and the full-time plan promised to accomplish two things in this regard. First, it would reorient the medical profession from attending to the needs of the well-to-do patients to serving the interests of society and humanity at large, by harnessing the income of medical

¹⁴ Brown, p. 158.

¹⁵ Brown, p. 113.

professors and researchers to university salaries rather than patient fees. Second, by moderating physicians' incomes, the full-time plan would reduce the overall costs of medical care placing them within the reach of all classes. If society relies on doctors to fulfill important social functions, reasoned the captains of corporate philanthropy, then "the interests of the social order" must be considered first in any reform proposal.¹⁶

The Full-Time Question at Columbia

In the agreement of affiliation, reached in the spring of 1911, Columbia University did not formally commit itself to a jointly constructed medical center, but the leaders of both the Presbyterian and P&S were resolved on that goal. In May of 1915, after a thorough canvass of the upper part of Manhattan, the Presbyterian's Building Committee reported that a three-square-block plot of land in the Washington Heights area, bounded by 165th and 168th Streets on the south and north, Broadway on the east and Fort Washington Avenue on the west, was the best site available. At the time, the property was valued at about one and a half million dollars. Because other parties had been negotiating for the property, Edward Harkness decided to secure the option with \$77,000 of his own money but announced that the Hospital was under no obligation if it decided against the purchase. The Managers agreed with the Committee that it was indeed the best site and authorized its purchase provided that Columbia gave proper assurances that it would share in the purchase of the property and would eventually reconstruct its Medical School there.

Columbia Trustees declared that the University could agree to share in the purchase of a site only if they could raise their portion in five years. Forced to be content with these assurances, Presbyterian had nonetheless proceeded with a plan to

¹⁶ Brown, p. 147.

purchase, hoping that Columbia would be able to come up with at least its half of the down-payment – \$362,500 – required by September. Having raised their share by August 20, the leaders of the Presbyterian were disappointed to learn that Columbia did not have nearly enough. A tense correspondence between Edward Harkness and Columbia's President, Nicholas Murray Butler, ensued. Butler reiterated that Columbia made no commitments to share in the down-payment, while Harkness accused University leaders of not doing nearly enough to secure the necessary funds. Presbyterian' Board of Managers moved to extend the option on the property and give Columbia two more months to secure the funds. Two days before the option was set to expire, Columbia's President confidently announced that he expected to receive a gift from a certain donor on that very day and that the plan to purchase the property could now be finalized. Alas, the gift never came and the Washington Heights site appeared to be lost for good.¹⁷

As the year wore on, it became increasingly clear that America would sooner or later be drawn into the war raging in Europe. Columbia's failure to join in the purchase of the Washington Heights site and the preparations for the war, which began at Presbyterian months before the United States officially entered the conflict, had the inevitable effect of deferring further planning of the joint medical center. At the end of the year, however, Presbyterian and New York hospitals began to explore the possibility of a merger between the two hospitals and the two medical schools affiliated with them. Negotiations seemed very promising and by the end of the spring all four institutions were apparently on board. A month later, however, Columbia

¹⁷ Albert R. Lamb, *The Presbyterian Hospital and the Columbia-Presbyterian Medical Center, 1868-1943* (New York: Columbia University Press, 1955), pp. 89-97.

declared that there were “insuperable legal obstacles” to the merger and, with that, the whole proposal was abandoned.¹⁸

Soon afterward, Columbia invited Dr. Abraham Flexner to prepare a memorandum on medical education in New York with special emphasis on the question of the Columbia-Presbyterian affiliation. Not surprisingly, Flexner’s memorandum closely followed the premises of his famous 1910 Report on medical education. In a nutshell, Flexner recommended that the Hospital and the School be reconstructed in one location, all clinical instruction concentrated in the Presbyterian Hospital, and the clinical staff reorganized on the full-time principle. Following this study, President Butler wrote to the Rockefeller and Carnegie foundations to state Columbia’s intentions to proceed with the project of the Medical Center essentially along the lines recommended in Dr. Flexner’s memorandum. On the basis of this letter, the Carnegie Foundation for the Advancement of Teaching and the two Rockefeller philanthropies – the Rockefeller Foundation and the General Education Board – stated their interest in contributing one million dollars each to the project and conferences between the representatives of the Medical School, Presbyterian Hospital, and the two foundations ensued. As a result of these talks, all parties, including Columbia, which was represented during the conferences by President Butler, agreed on the plan which included all the main recommendations developed in Flexner’s memorandum.¹⁹

The official account of these events is consistent with an elaborate subterfuge which the Rockefeller foundations used to push its full-time project. When selected medical schools were approached with grant offers, the foundation officials made it very clear that the adoption of a strict full-time appointments in all departments was a

¹⁸ *Ibid.*, p. 125.

¹⁹ *Ibid.*, pp. 127-128.

non-negotiable condition. They were careful, however, that such communication was made orally and confidentially and that the written proposal to adopt the full-time system emanated from the institution, not the foundations. According to this fiction, institutions themselves proposed to institute strict full-time requirement and, moreover, chose to be bound by elaborate contracts which invariably included a clause stating that if the full-time plan shall be “abandoned, substantially modified or departed from” without the consent of the grant-making foundation, the university will, upon demand of the foundation, return its grant.²⁰ The foundations made sure that prior correspondence was orchestrated in a manner that supported this myth. The events that followed made it abundantly clear that both the Columbia’s solicitation of Flexner’s study and the President Butler’s “proposal” to the foundations were typical steps of this process.

Shortly after publicly agreeing on the terms of the Rockefeller and Carnegie grants, Columbia’s President wrote two confidential letters to the President of the Presbyterian, Mr. William Sloane, in which he vehemently objected to the main points of the Flexner’s report and declared that the University could not go through with the plan. He declared that the terms of the grants were “so reactionary and so antagonistic to the best interests of the public, of medical education, and of Columbia University, that they will not, under any circumstances be approved by us.”²¹ Obviously, Columbia desperately needed the money promised by the Rockefeller and the Carnegie foundations but President Butler and the Dean of the Medical School chafed under the compulsion to submit to the conditions imposed by the outsiders in return for receiving from their largesse.

²⁰ Brown, p. 172.

²¹ Lamb, pp. 130-131.

This turn of events raised serious concerns among Presbyterian's leadership. The three key figures on its Board who represented the Hospital at the negotiations – Edward Harkness, William Sloane and Henry W. deForest – supported the conditions stipulated by the Rockefeller foundations. As the letter accompanying his gift to the Hospital testified, Edward Harkness shared the basic belief of the Rockefeller and Carnegie foundations that medicine's "real underlying province and mission to humanity lies more particularly in preventing disease than merely curing it" and his vision of how modern scientific medicine ought to be organized was in substantial agreement with that of the foundations' leaders. Understandably, Harkness and his supporters among the Presbyterian's Managers were outraged at Columbia's resistance and President Butler's personal backing of the conservative members of medical faculty. Either out of desperation or in hope to exert the last bit of pressure, the Managers resolved to cancel the affiliation agreement of 1911 and sent an official notice to that effect to Columbia's Trustees.

Columbia Trustees agreed with President Butler's position but declined, at this time, to approve the cancellation of the affiliation agreement and asked for another round of negotiations with Presbyterian. What transpired during the nine months between January 18 and October 22, 1918 is not known because the official reports of the negotiations between Presbyterian and Columbia that took place during this time are missing from the records. According to Dr. Lamb's account of the history of Presbyterian Hospital, the most plausible explanation of the gap in records is that these negotiations contained so much open and personal criticism that the Managers decided at some later date to withdraw or destroy them.²² When the dust settled, President

²² Lamb, p. 135.

Butler withdrew from the negotiating committee for Columbia and a new dean was appointed to head the medical school.

Dean Darrach's Memorandum

Shortly after succeeding Dr. Samuel L. Lambert as the Dean of the College of Physicians and Surgeons in summer of 1918, Dr. William Darrach wrote a 'Memorandum on the School of Medicine,' in which he supported the view that the clinical departments should be restructured on a full-time basis and proposed a concrete plan of organization. It is apparent that the memorandum was meant to serve the same purpose as President Butler's earlier "proposal" to the foundations; less clear is the extent to which Dean Darrach believed what he wrote. Regardless of its sincerity, the memorandum outlined a specific form in which the full-time plan would be adopted at Columbia and serve as a telling background for the rhetorical strategy of retraction.

Dean's memorandum opened with an appropriately forceful affirmation of the holy trinity of the new scientific medicine – "teaching, research, and the care of the sick" – which was to be embodied in its new temple, the university medical center.²³ To pursue this tripartite goal, declared Darrach, Columbia Medical School required an intimate geographical and functional union with a teaching hospital, limitation of the number of students, and reorganization of the main clinical departments of a full-time basis. All three, of course, represented the main demands of the foundations.

The major portion of the document was devoted to the discussion of the full-time plan. Darrach wrote that "the heads of [the basic science] departments have long been on the full-time basis, and with no legislation ... voluntarily refrained from any

²³ All quotations from Dean Darrach's memorandum are from ' "Memorandum of the School of Medicine" by Dr. William Darrach', December 13, 1919, reprinted in Willard C. Rappleye, *The Current Era of the Faculty of Medicine, Columbia University, 1910-1958*, (New York: Columbia University Press, 1958), Appendix D, pp.130-137.

outside employment.” In view of the most salutary results in teaching and research that the ‘full-time’ organization produced in basic science departments, it was imperative that the main clinical departments also be reorganized on the full-time basis: “Medicine and Surgery immediately, and Pediatrics [and other departments] as soon as financial and clinical facilities permit.” As Dean Darrach understood it, the essential principle behind the full-time organization was that “the dominating group of men ... must be free to concentrate their energies on their university and hospital work.” In the clinical departments, however,

[t]here are two main factors which tend to interfere with this freedom, no matter how sincere the intentions of the men may be. These factors are insufficient assistance and the distractions of private practice. By providing the full-time men with sufficient assistance, professional, clerical, technical and menial, he may relieve himself of such unnecessary details as he desires. He must also be protected from the demands of private practice.

Private practice presented particular difficulties for the most talented members of the clinical faculty because “[a]s a man’s value as a clinician increases, the demands made for his services by the public naturally increase.”

If this increasing demand is satisfied he will have less and less time for his university duties. It therefore becomes necessary for these men to control the amount of private practice they shall do and the conditions under which it is done.

“There is apparently,” opined the Dean, “but little question in the minds of medical educators as to the wisdom and necessity of this main principle [but] there is, however, some doubt and much discussion concerning the details of organization [as] evidenced by the wide variation among the plans now in force or planned throughout the country.” There were five possible ways in which the limitation of the demands of private could be achieved.

- Plan 1. No private practice and no outside employment.
- Plan 2. Private practice at the discretion of the clinician but no fee is paid for such service.
- Plan 3. As in Plan 2 except that the fee is paid to the University.
- Plan 4. Private practice for fees allowed in such limited amounts that it does not interfere with the thorough, efficient and sincere fulfillment of his academic duties.
- Plan 5. Unlimited private practice within the hospital.

According to Darrach, Plan 1 has not been tried anywhere, Plan 2 was in effect at the Rockefeller Hospital, Plan 3 was adopted at Johns Hopkins, Plan 4 was instituted in several schools and Plan 5 was the one suggested for Columbia and Presbyterian in 1911, but not implemented. The Dean recommended the Columbia Medical School adopt Plan 2.

To explain his choice, Dean noted that Plan 1, in which the clinicians would limit their clinical experience to the wards of the hospital and the dispensary, was “the simplest method” from “an administrative standpoint.” However, he thought it “unwise to deprive the public of these men’s services, for patients who are not eligible for the charity wards are at times of great scientific, educational, or humanitarian interest.” Plans 2 and 3 removed the above objection. However, the payment of the patient fees to the University, which was the practice at Johns Hopkins, was “strongly criticized by many men and is not entirely satisfactory to some of the men who have been working under that arrangement,” wrote Darrach alluding, undoubtedly, to Janeway’s article. Somewhat puzzlingly, Plan 4, under which the hospital would provide a number of private office facilities to the clinicians who would then “spend a large part of, if not all, of their time in the school and hospital” was rejected because “it could not be combined with Plan 2 without introducing a discordant element into the situation.” Finally, Plan 5 was “the one suggested by the Faculty of the College of Physicians and Surgeons in 1911 [but did not] meet the requirements of today, as with

unlimited facilities within the hospital such private practice might well claim the major portion of a man's attention."

Thus, the Dean proposed to organize the clinical departments such that "the director with all of his associates ... and as many of his other assistants as he desires and can afford, shall be on the basis of Plan 2." This scheme would allow physicians to "see private patients at their discretion for scientific, educational, humanitarian, or personal reasons" but since no fee would be paid, it would protect them from the excessive demands of private practice by "removing the financial inducement."

Subsequent events would make it clear that, in truth, Plan 2 was preferable only to Plan 1. Whether charging no fees at all, as in Plan 2, or turning the fees over to the University, as per Plan 3, was more repugnant to the clinicians' sense of 'justice' is hard to say, although the latter certainly made more economic sense. Plan 5 was probably the most desirable, closely followed by Plan 4. For the time being, however, Dean Darrach could not say that and had to paint his ideal of the medical center's organization within the confines of what was acceptable to the foundations. So limited, Dean Darrach proceeded to elaborate all the advantages that ought to be secured for those who will head the full-time departments. "The fundamental principle upon which these departments shall be reorganized," insisted Darrach, "is that the control of each main clinical department shall be vested in a director." What he envisioned was admittedly a more hierarchical organization than that which traditionally obtained at medical schools.

At the head of each shall be placed a man of such training, ability, and character that he may assume full responsibility for and the direction of the general policies of the department, the character of the teaching, the hospital service, and the nomination of his associates. It shall be his duty to develop a modern clinic of the best type.

Greater power required greater resources and the memorandum dreamily envisioned full wards and plentiful assistants to relieve the university physicians from tedious administrative and technical tasks. “The head of the department,” he pronounced, “shall be given every facility to develop a well-rounded, modern clinic, with sufficient clinical material in both wards and dispensary, with the specialized assistants, professional, clerical, and menial he requires, and the necessary laboratories.”

The new men of science would have to be properly rewarded. “The salary of [full-time] men ... should be sufficient to make them independent of any private work and that of the director should be enough to allow him to assume the position in the world that he deserves.” Further indulging his fantasy, Dean Darrach declared that the head of each department “should have as much time for constructive thought and productive leisure as the head of a large industrial concern.” That said, physicians’ primary motivations had nothing to do with either money, or power.

Of more importance than salary for either type of man is the proper arrangement of his work, so that he shall be freed from unessential details and useless waste of time. In the end the opportunity to carry on teaching and research under wholesome conditions is the most effective force for bringing into the medical school men of ability and ideals.

On the whole, Dean Darrach’s memorandum succeeded in striking a consistent note but some statements were obvious ‘red flags.’ Although he stated that unlimited private practice would interfere with clinicians’ university duties “no matter how sincere the intentions of the men may be,” the Dean preferred not to dwell on the crass material interests. The question was ethical, not economic, he contended.

The success of any plan will depend on the character of the man in question and the spirit of the school. Any form of legislation will be unavailing if the wrong men are appointed to these positions. There are many forms of

distraction besides private practice, especially in New York City, which might lure a man from proper fulfillment of his academic duties.

In a strange prelude to his careful consideration of five possible ways to institute the full-time plan, Darrach refused to grant importance to the specific rules of implementation.

The main purpose is to obtain a more truly university type of clinical teacher. The full-time plan is a means to this end – a method by which it may be obtained. Neither the time element nor the question of fees is, in itself, the essential point, and these must not be confounded with the primary object.

More mundanely, the memorandum also sounded concern with financial feasibility of strict full-time plan.

Even if it were advisable to have the entire department on a full-time basis, the expense in certain departments would be enormous and the plan therefore impractical. [T]he conduct of hospital, dispensary, and school requires additional assistance from men giving only part of their time to hospital, dispensary and school. The extent to which they are used should vary with the ideas and plans of the respective directors, provided they are not made an essential part of the hospital organization.

Finally, the Dean ended his memorandum by saying that “[t]his plan represents the best thought of the present time but will naturally be subject to such modifications and changes in future years as larger experience may suggest and justify.”

There would be no need to read anything into these lines if it were not for the fact that these very statements would later be used to renege on the full-time plan as outlined in the Dean’s memorandum. For the time being, however, Dean Darrach’s memorandum formed the basis for reopening the negotiations between Columbia, Presbyterian, and the foundations, which resulted in the signing of a new affiliation agreement on February 10 of 1921. The agreement was conditional on the University’s raising three million dollars for construction costs. Three months later,

the Carnegie Foundation, the Rockefeller Foundation, and the General Education Board each donated one million dollars to Columbia and the second agreement became effective.

As an unexpected surprise, Edward Harkness announced that he and his mother were giving the Hospital and the University the twenty-two acre site at the Washington Heights. It turned out that, in 1915, when the site appeared to be lost due to Columbia's lack of funds, the Harkness family secretly purchased it to hold until such time when the differences between Columbia and Presbyterian were ironed out and a solid basis for affiliation established. With that, the real work of planning the Medical Center could finally begin.

Inauguration and Repeal of the Full-Time Plan at Columbia

It appears that, for a while, Columbia and Presbyterian indeed tried a strict full-time system as outlined by Dean Darrach and agreed to by all the sides to the negotiations. The main clinical departments – Medicine and Surgery – had started on Plan 2 on July 1, 1921.²⁴ As could have been expected, the announcement and implementation of the full-time plan prompted a new wave of resignations. It seemed, too, that much of the reorganization was affected by transplanting a large group of clinicians from Johns Hopkins, who had already worked there the full-time system under, to New York.

The Medical Service was reorganized under Dr. Walter Palmer who was at Johns Hopkins at the time of his appointment. With him eight other physicians and a chemist came to Presbyterian from Johns Hopkins. After a number of resignations among the old staff, all of the higher posts in the Medical Service were placed on a full-time basis. Lower-level positions, however, remained with the part-time

²⁴ Lamb, pp. 189-190.

appointees. In the Surgical Service, full-time reorganization was more drastic. On July 1, Dr. Adrian Lambert resigned from the post of Director of Surgical Service. The new Director, Dr. Allen O. Whipple decided to reduce the surgeons with attending rank from thirteen to five and place all of them on strict full-time basis. As a result, ten surgeons left the staff and two new appointments were made.²⁵

The retrenchment of the strict ‘full-time,’ however, began almost as soon as the system was instituted. Less than six months after the inauguration of the full-time plan, dissatisfaction became so apparent that Edward Harkness gave a dinner at his house on January 17, 1922 to discuss the matter. Dr. Lamb, who was among those invited to this informal conference, reminisced that their host had been convinced by Dean Darrach that Plan 2 was not only sound but perfectly acceptable and, therefore, it came as a considerable surprise to him that “there were features of the full-time program not altogether satisfactory.” In an atmosphere of their informal exchange, however, the representatives of the clinical faculty made it clear that the official acceptance by the faculty of the 1921 agreement “had *not* meant that all who consented to participate in full-time were in full accord with all of its provisions.”²⁶ Apparently,

[t]he clinicians had all been most anxious to have the affiliation consummated between Presbyterian and Columbia, especially after the tense and protracted negotiations of ten years. Since the plan proposed by Dean Darrach’s “Memorandum” had been favorably received by both institutions and by the three foundations, the doctors had accepted the plan whole-heartedly even at the temporary sacrifice of personal convictions and financial security. The trial of the plan, they had hoped, would lead to the elimination of many difficulties ...

²⁵ *Ibid.*, pp. 166-169.

²⁶ Lamb, pp. 190-191.

The dinner meeting resulted in a consensus on two issues: that the policy of not charging fees for services to private patients was unsound and that the current salaries were inadequate to attract and retain sufficient number of high-caliber clinical faculty. In accordance with these conclusions, the Medical Board submitted to the Medical School's Committee on Administration a document outlining the changes to the full-time plan that had been agreed upon at the dinner meeting. Proposed changes were three-fold: private patients should be charged; the Hospital should collect such fees and turn them over to the University's special fund for research and teaching; and the salaries of several full-time clinicians should be adjusted so they may cope with the cost of living in New York. In addition, the Medical Board recommended that the clinical departments be organized on a more flexible model than the strict full-time and include three categories of appointments: "(1) full-time men; (2) men with offices and sufficient private beds in the Hospital, confining their work entirely to the Hospital, but receiving fees directly from patients; (3) part-time men, limited service to the Hospital, with offices outside."²⁷

After more conferences, the Joint Administrative Board and the University sanctioned the following changes in the full-time arrangement. Private patients would be charged fees according to the schedule fixed by the doctor in attendance and approved by the Superintendent. The fees would be collected by the Hospital and credited to a fund for paying full-time clinicians supplementary salaries based upon the expected fees. The Hospital would estimate the amount it expected to collect each year and pay this sum in equal monthly installments to the University. Any discrepancy between the estimated and collected amounts should be adjusted the following year. These changes were to become effective on July 1, 1922.

²⁷ *Ibid.*, p. 192.

What the Medical Board won in this round of its campaign to repeal the full-time system was essentially a change from Plan 2 to Plan 3, the Johns Hopkins plan. It will be recalled, however, that Dean Darrach rejected Plan 3 because “the payment of the [patient] fee to the University [was] strongly criticized by many men and [was] not entirely satisfactory to some of the men who have been working under that arrangement.” Although the fees collected from private patients made possible a 25 to 50 percent increase in clinicians’ salaries, the new arrangement did not address what appeared to be the main issue of contention. Clinicians were especially incensed by the requirement that patient charges be approved by the Superintendent and collected by the Hospital. In line with the official stance of the organized profession, Columbia’s clinical professors considered both to be dangerous precedents of administrative control of professional fees.²⁸ Less than a year after the first round of changes to full-time system were put in effect Dean Darrach was moved to appoint a committee to propose a thorough revision of the whole full-time program.

The Report on the Organization of Clinical Departments

The committee’s recommendations were summarized in a Report on the Organization of Clinical Departments which called for abolition of all restrictions on private practice by the members of the clinical faculty. Committee’s argument rested on three main ideas. First, the full-time requirement was unnecessary because, as a

²⁸ According to Dr. Lamb’s account, the new arrangement created financial hardship for Presbyterian, as well as a conflict between the Hospital and the University. It appears that the arrangement did not take into account that provision of doctors’ private offices would constitute an operating expense to the Hospital and the latter soon tried to renegotiate the amount of its payments to the University. Until such adjustments were made, however, the increase in Presbyterian’s revenues from the hospitalization of private patients failed to offset the payments to the University. In Lamb’s words, physicians “were moved to accept all the private patients they could possibly handle in order to make up the deficit.” (p. 193) Like much of the official discourse surrounding the ‘full-time’ affair at Columbia, this account does not appear wholly credible. The issue of payments by the Hospital to the University appears to be nothing more than a matter of adjustment through proper accounting. While it is true that both hospitals and universities were notoriously lax in their accounting practices in comparison to business corporations, nevertheless, the problem, as described, does not appear to entail the changes that are attributed to it in Lamb’s account.

members of a profession, physicians were above material interests and economic motives. Second, the restrictions on private practice or, for that matter, any other externally imposed rules, were inimical to professional work and would not be tolerated. Third, the full-time organization of the *clinical* departments was deeply unfair to the members of the *non-clinical* departments. We examine each in turn.

The authors of the Report began by stating that the argument for the necessity to place clinical faculty on the full-time basis rested on erroneous assumptions. The initial impulse to reorganize clinical departments, argued the authors, arose out of “the general dissatisfaction felt at many medical schools where the clinical teaching and scientific productiveness were considered inferior to those in the fundamental departments.”²⁹ The inferiority of the clinical departments was believed to be due to the fact that “the clinicians spent less time on their school work and took less interest in it.” To remedy the situation, it was suggested that “if the financial attraction of private practice was supplanted by a high salary and the individual’s whole energies confined to University channels, true excellence of teaching must result.” Two assumptions, then, informed the views of those who advocated full-time in clinical departments: (1) “that only by offering larger salaries could clinicians [truly devoted to teaching and research] be secured;” and (2) that placing clinicians on salaries and restricting practice outside of the teaching hospital “were necessary to protect them from the demands of what is commonly known as private practice.”

There were a number of fallacies inherent in these assumptions, argued the Committee. The first of these was that physicians were or could be motivated by economic interest. To the authors of the Report, the restriction of private practice imposed by the full-time plan was insulting because it implied “that the clinicians

²⁹ All quotations from the Report are from “Appendix 4, Summary of Report of Committee on Organization of the Clinical Departments,” reprinted in Lamb, *The Presbyterian Hospital*, pp. 443-449.

must be prevented from succumbing to their own weakness” and added that “[s]uch an implication [was] not the best basis for continued cordial understanding and loyal service.” The architects of the full-time plan, warned the Report, failed to take into account that “the services of the most desirable clinicians cannot be secured merely by offering high salaries” and that neither money, nor facilities could “buy their continued services under conditions which are burdensome and restrictive.” The attraction of private practice did not stem from its monetary rewards but from professional satisfaction that physicians derived from it. Unlike medical faculty in basic science departments who are “wholly devoted to the application of science,” clinical professors “must practice an art or cease to be clinicians.” By imposing full-time requirements on clinical departments, “[h]uman nature was to be cut to fit an idea.”

More precisely, the issue was not so much about *human* nature but the nature of the *professional man*.

[I]f the University has secured the right type of man and if it has provided him with a fair salary and with facilities and opportunities commensurate with his needs and desires, he will neither want to do too much private practice nor will he have to. His tastes lie in other directions. There is no need for special prohibitions.

Mindful of the incontrovertible record of Johns Hopkins, the Committee remarked that it was “idle to ask whether men work better under agreeable than under disagreeable conditions.”

Good work has been done in both ways. But it is generally accepted that men work longer and more contentedly and with less wasted effort under congenial working conditions. And it may be urged that the most intelligent men work best in an atmosphere of confidence and are unlikely to abuse it, for dishonesty is unintelligent.

Regarding Columbia's own experience with disagreeable working conditions, the authors insisted that, in assessing the work of clinical faculty under the full-time system, "most of the advantages must be credited to the clinicians who have done the work and that most of the disadvantages must be debited against the plan under which they did it." When it came to professional and scholarly work, what mattered was not the structure of the institution, but the character of men working within them. 'Men over rules' was the idea that would sound frequently in the pages of the Report.

Contradicting their own argument that the full-time plan was to be made attractive by offering large salaries, the authors of the Report warned that "many of the clinicians limited to unremunerative practice felt that they would be financially unable to continue working much longer under this plan." In general, they admitted, the restrictions on private practice were "uncomfortably felt by those upon whom they had been imposed" and the University was unable "to find enough men willing to work under the plan." This was so despite the fact that that, as the Report made clear, the salaries of the clinical professors, both under Plan 2 and Plan 3, were considerably higher than those of the non-clinical colleagues. Lofty statements notwithstanding, then, here was what should have been an embarrassing and puzzling revelation that the clinical professors felt entitled to not only *larger* but *much larger* income than that received by non-clinical faculty.

This unsettling proposition, however, was quite minor in comparison the audacity of the rhetorical move that followed. Soon after the establishment of the full-time plan in all departments, said the Committee, it began to be widely felt that the arrangement was "unfair to the non-clinical departments in attracting men away from them by the higher salaries and wider opportunities of similar positions in the clinical departments." Apparently, the fact was that either non-clinical departments were staffed with the 'wrong' men or, unlike their clinical colleagues, non-clinical faculty

was too weak to resist the lure of the higher pay. The disparity in salary was uncomfortable for the clinical professors too, who were immediately set apart “as objects of interest, admiration, envy or disdain according to the spirit and inclination of the commentator.” Admittedly, said the Committee, non-clinical faculty were far more affected and it is their plight that most concerned the authors of the Report. “Granted that the right men are doing the work, there is one infallible test for the success of any plan of organization: Has it operated to their satisfaction and to the satisfaction of their colleagues in the other departments, or has it not?” Answering its own question, the authors of the Report unanimously concluded that the plan has not operated to the satisfaction of their non-clinical colleagues.³⁰

Rather than a source of the clinicians’ handsome incomes, private practice was cast in the Report as a matter of academic freedom. The full-time system was “not a real University basis for it was lacking in that essential academic freedom which is a primary requisite in University departments.” It imposed upon the clinical faculty of the medical school “restrictions which have never been laid upon the officers of any other departments of the University.” The burdensome restrictions on private had to be lifted in order to restore the “freedom of choice which does not now exist in the Departments of Medicine and Surgery.” All the Committee proposed was “to authorize the Departments of Medicine and Surgery to assume the same rights and duties as the other Departments of the University” and implied nothing more than “the removal of the restrictions regarding private practice and the reduction of the salaries in [clinical] Departments to conform with those of other Departments in the Medical

³⁰ In the matter of fact, the placement of the clinicians on the full-time plan had actually greatly reduced the disparity between their income and the income of their basic science colleagues. Higher salaries approved for the full-time clinical faculty were a way of making the plan at all viable. The use that the authors of the Report made of their non-clinical colleagues was, then, quite astounding in its dishonesty and underscored the degree of rift between the two groups, which we will have an opportunity to discuss below.

School.” Expressing the will of the entire medical faculty, the Report demanded “the removal of those distinctions between Departments which have become invidious distinctions during the trial of [full-time] experiment.”

The full-time requirement in clinical departments, argued the Committee, was adopted on an experimental basis, the fact clearly indicated in Dean Darrach’s memorandum.

The radical plan – incorporating a definition of Full-Time service for clinicians which had not before been tried out by any Medical School – was finally adopted as offering a chance for a very clear-cut demonstration of the desirability or undesirability of the strictest sort of full-time for clinicians. It was adopted on trial. This was definitely stated in the last paragraph of the Memorandum of December 13, 1919, and the clinicians of the Departments of Medicine and Surgery undertook with the utmost seriousness and with full appreciation of its difficulties the scientific trial of this important experiment.

According to the Committee, “the experimental trial of this plan of full-time for clinicians has been completed, the data recorded and the conclusions drawn” and now it was time to announce that “the plan has been proven unsatisfactory.” However, insisted the authors, “it cannot be too strongly emphasized and it must be very clearly understood that this proposition for a change in the plan of its application does not in any way imply an abandonment of the principle of full-time for clinicians.” How could these two seemingly contradictory statements be reconciled? “The principle of full-time,” wrote the Committee, “bears the same relation to the plan of its application as the spirit of a law bears to the letter of that law.” That was precisely what Dean Darrach meant when he wrote that

[t]he main purpose is to obtain a more truly university type of clinical teacher. The full-time plan is a means to this end – a method by which it may be obtained. Neither the time element nor the question of fees is, in itself, the essential point, and these must not be confounded with the primary object.

Elaborating Dean’s thought, the Committee insisted that

[t]he real essential is to live up to the spirit of full-time rather than to preserve its empty name. This cannot be effected by the imposition of restrictions nor by the lure of extraordinary salaries. It can only be accomplished ... by securing for the clinical departments clinicians of the highest caliber who desire to work in this spirit, the spirit of service.

Turning outright Hegelian, the authors of the Report argued that “the University ideal of teaching can be lived up to more closely [when] spiritual leadership rather than restrictive legislation will be the impelling force.” In effect, what the Committee was proposing was not a repeal of the ‘full-time’ but its *transcendence* and the higher aim for which they reached had its own capital-letter name.

[W]e cannot help feeling that a new tradition has arisen within those years: a tradition of Full-Service rather than of Full-Time; a tradition which has been founded by no one Department alone but which can be shared equally by all. We feel that the present Directors and their Associates in the Departments of our School are the type of men who will foster this tradition. And we confidently expect that, under their inspiring leadership, the troublesome distinctions between full-time and part-time will eventually disappear in the general desire to give full service: full-service which can be rendered by any man – whether he works one hour or eight hours or twenty – if he gives the best there is in him to the University.

If all the lofty rhetoric did not suffice to convince their audience, the committee laid out the more prosaic reasons to return to the old order.

It is expected that the clinical staffs can be considerably increased in numbers without an increase in cost to the University. ... [T]he young men who need financial help and the older men who object to the present restrictions can be brought back into the service of the Departments. Thus the present burden of work in the O.P.D. clinic and in the wards and clinical laboratories, which is now carried by a few, can be better divided among an adequate number of workers; and provision may be begun for the greater burden which is to be expected in the new development of the proposed Medical Center.

If the proposed changes received approval, wrote the authors in conclusion, one thing would be certain: “the officers of the Medical School will again be working

under an organization plan of their own choosing.” This, however, was exactly what the leaders of the Rockefeller foundations wished to prevent.

The Defeat of the Full-Time Requirement

The trustees of both institutions approved the proposed changes and, effective January 1, 1924, restrictions concerning private practice were lifted and the salaries in the clinical departments were to be gradually reduced to conform with those in the non-clinical. The change, however, was not reported to the three foundations upon whose funding Columbia was relying for financing the construction of the new Medical School building. The foundations’ officers first learned about it from a brief paragraph in the *Columbia Alumni News* dated May 30, 1924 which read:

During the past year the Faculty of the Medical School advised the abandonment of the “full-time” teaching system in P. and S., and a return to the part-time system now general throughout the University is being worked out.³¹

The General Education Board and the Rockefeller Foundation were outraged at what they considered an act of bad faith and at the fact that they had not been consulted about the change.³² They informed Columbia that, since full-time had been ‘abandoned,’ they were no longer under obligation to supply the grants. Both Columbia and Presbyterian officials were naturally very perturbed about this turn of events. Several conferences were hastily called but, as the year drew to a close, a solution to the crisis had yet to be found.

On January 9, 1925, Columbia issued a resolution reassuring Presbyterian that there was “no change in the determination of Columbia University to proceed with the Medical Center.” Unfortunately, it could offer little comfort since the University

³¹ Lamb, p. 221.

³² According to Dr. Lamb’s account the Carnegie Corporation never entered any objection to the change or threatened to withdraw its gift of \$1,000,000.

simply did not have an alternative source of funds and its assertion could not quiet the fears about the fate of the whole project. The Rockefeller institutions remained adamant and there was even talk of a suit against Columbia for breach of contract.³³

By Fall of 1925 there was still no settlement and the two Rockefeller foundations announced that they intended to cancel their agreements with the University. Meanwhile, Dr. Walter Palmer, who held the joint posts of Director of the Medical Service and Chair of Department of Medicine, had been working on a proposal for settling the dispute. He was well respected by the authorities of the foundations, and Columbia trustees urged him to seize the dwindling chance of saving two million dollars of grants.

What Dr. Palmer accomplished within the next few weeks in his talks with foundation officials may at first seem to be nothing short of a diplomatic feat. In a memorandum which he submitted to the Rockefeller foundations, Dr. Palmer pointed out that a considerable number of physicians in the Medical Service – nine, to be precise – would prefer to work on a full-time basis. However, four out of nine, including himself, “found it necessary to take advantage of the privilege of supplementing their salaries by limited private practice in the Hospital.”³⁴ The memorandum, then, proposed salary increases for all nine doctors plus another \$11,000 to hire a new Associate Physician and three Assistants. Increases requested ranged between 13 and 67 percent of current salaries and the sum of all funds requested totaled \$28,000 a year.

If the salary increases were effected, wrote Dr. Palmer, all nine physicians would work on a form of full-time, while retaining the right to see private patients of interest to them. The fees collected from private patients would go into a fund to be

³³ Lamb, p. 221.

³⁴ *Ibid.*, p. 222.

used for purposes determined at a later time. Dr. Palmer estimated that about \$68,000 were needed for the next two and a half years, until the Service was completely established at the new Medical Center, at which time it would be possible to cover salary increases from the regular budget. Dr. Palmer's proposal, then, was that the foundations provide the relatively small sum of \$68,000 to permit full-time work by these physicians. In conclusion to his proposal, he stated:

In the light of the turmoils and struggles of the last four years, the above plan may appear to be a reversal of opinion. This is not the case. From the very beginning, the desirability of providing for suitable men relieved of the necessity of practicing to supplement their salaries in order that they might devote their time and energy to teaching and research has been recognized and stated. That this can be accomplished in association with men in active practice has been amply demonstrated.³⁵

In mid-December, Dr. Palmer represented the Medical School and Hospital at a decisive meeting with Abraham Flexner, who represented the General Education Board, and Thomas Debevoise of the Rockefeller Foundation. Apparently, Mr. Debevoise had with him the papers necessary for canceling the agreements with Columbia. The copy of Dr. Palmer's memorandum had been already circulated among all the parties to the dispute and now he made an official presentation of his case. Dr. Palmer declared emphatically that there had not been the slightest intention of abandoning the full-time principle, but, on the contrary, a special effort to increase its usefulness. A number of doctors on the Medical Service were already working on full-time, as the memorandum showed, and others wished to do so when the funds became available.

In what seemed like an unlikely event, Dr. Palmer's plan was accepted and Abraham Flexner announced that the General Education Board would provide the

³⁵ *Ibid.*, p. 223.

\$68,000. Columbia emerged from the shadow of the long crisis not only with the original two million dollars of grants but with an additional sum to increase the salaries of the Medical Service. The full-time arrangement applied only to certain men who did not object to the restrictions. The biggest victory of all, however, was to be found in the language of the new agreements with the two foundations. That with the General Education Board stated that “... nothing in this agreement shall be understood to impair the responsibility and right of the University to make in future years such changes and modifications in the organization and conduct of the Medical Clinic as educational and scientific experience may, in their judgment, justify.” The agreement with the Rockefeller Foundation placed still fewer obligations on Columbia: “It is understood that the University will give a trial to the plan for which these funds are contributed but will not be obligated to continue any particular type of organization or method of instruction.”³⁶

Behind this unexpected reversal of Columbia's fortune lay deeper changes in the policy of the philanthropic foundations. One year after the General Education Board extended to Johns Hopkins a one and a half million dollar grant on a condition of strict full-time organization of all departments, Dr. Welch reported that the system was a great success. Encouraged by their success at Hopkins, over the next few years the Rockefeller foundations made grants to Washington University at St. Louis, Yale, and the University of Chicago on similar conditions. Opposition to the full-time plan, however, did not abate either within or outside the university circles. Dr. Janeway's departure from Johns Hopkins and his public criticism of its full-time plan were uncomfortably felt by the foundations but the biggest blow came from Harvard.

³⁶ *Ibid.*, p. 224.

The General Education Board invited Harvard to apply for a grant while the details of its contract with Johns Hopkins were being worked out. At the time, Harvard could really use the money but the chances that its clinical faculty might be persuaded to accept the strict full-time plan appeared quite low. Opposition to strict full-time policy at Harvard was led by the renowned neurosurgeon Harvey Cushing and the former dean of the school Henry A. Christian. Like other faculty members, Cushing and Christian had lucrative private practices and refused to give them up. Cushing was also a brilliant researcher and his commitment to scientific medicine could hardly be doubted. He even offered his resignation to Harvard President Lowell, so as to not stand in the way of the medical school receiving the grant, but, as he undoubtedly knew, the President considered the famous surgeon more important to Harvard's academic reputation than the \$1.5 million dollars.³⁷

Lacking the clear support of the faculty, Harvard tried to obtain the grant by promising that clinical professors would "devote the major part of their time to school and hospital work," but could still collect fees from their private patients who they would see in offices located at the university hospital.³⁸ The chiefs of the Rockefeller philanthropies, however, refused to accept the diluted full-time plans which Harvard submitted to them over a period of several years. If exceptions were made for some schools, they would be able to lure the best clinical faculty from those schools who adhered to the strict full-time by matching their salaries plus allowing them to keep fees from private practice. In fact, the raiding was already in full swing and Johns Hopkins had to work very hard to keep their best clinicians.

The stature of the Harvard faculty, as well the incomes and interests involved, however, were too powerful and the Rockefeller foundations failed to make Harvard

³⁷ Brown, p. 167.

³⁸ *Ibid.*, p. 166.

accept their terms in return for grant money. Harvard also had an insider among the trustees of the General Education Board, the illustrious former president Charles Eliot, who shamed the foundation for systematic violation of its own official policy of non-interference with running of a recipient institution. The foundations, however, had far larger concerns to worry about than internal dissent and academic resistance.

The Rockefeller foundations operated in a tense atmosphere of popular, legislative, and political attacks on their founder. Of all the “robber barons” of the age, Rockefeller’s name was perhaps most vilified. The Rockefeller family hoped that philanthropy would help clear their name but, more often than not, the foundations were attacked as shameless ploys to cover up the injustices of the Rockefeller economic empire. When Rockefeller attempted to obtain a congressional charter for the new Rockefeller Foundation, the move was met with loud protest from working-class and Progressive leaders. Failing the passage of the charter bill in Congress, the Rockefeller organization found a more receptive mood in New York and was granted an unrestricted charter by the state legislature in 1913. But even here, anti-monopoly sentiments ran high and four years later a bill to repeal the Foundation’s charter was introduced. Although it did not pass, the investigation inflicted considerable damage to its public image.³⁹

The severest blow, however, followed the 1914 “Ludlow Massacre” at the Rockefeller-controlled Colorado Fuel and Iron Company, in which the company’s private militia and the state guard called to put down a strike shot to death six workers and set on fire the tents in which strikers’ families were forced to live, burning alive two women and eleven children. In response to public outrage, the Congress created the Commission on Industrial Relations to investigate not only the Ludlow affair, but

³⁹ Brown, p. 169.

also the broader relations between capital and labor and the role of philanthropic foundations. The Commission subpoenaed the senior and junior Rockefeller, Charles W. Eliot and Jerome D. Greene to testify about the activities of the Rockefeller Foundation. Its final report noted that the policies of the Rockefeller and Carnegie foundations were “colored, if not controlled, to conform to the policies” of the major corporations, which were in turn controlled by a “small number of wealthy and powerful financiers.”⁴⁰

As a result of these investigations, the foundations’ policies were coming under attack from the wider circles of Progressive era leaders. In 1914, for example, the National Education Association criticized the foundations for introducing undemocratic controls into the schools. Socialist and working class organs went further and regularly condemned the work of the foundations as a project of ideological control.⁴¹ In this climate, some of the trustees of the Rockefeller foundations feared that the tide of lower-class protest might force the government to take control over all educational institutions or, worse, limit the ability of economic elites to appropriate surplus wealth. Like many other prominent university figures, Charles Eliot also feared the future of great “injustice inflicted on those who have by those who have not, and corruption and extravagance in the expenditure of money raised by taxation.”⁴² In this regard, the foundations considered their investment in education and medicine the most effective means to prevent the ‘expropriation of the expropriators.’ With the waning of Progressivism after the war, such apprehension was probably unwarranted, but fears were not to be easily quelled.

⁴⁰ *Ibid.*, p. 170.

⁴¹ *Ibid.*, p. 169. For more on the general climate in which the foundations operated during this period, see W. A. Nielsen, *The Big Foundations: A Twentieth Century Fund Study* (New York: Columbia University Press, 1972) and R. Arnove, ed., *Philanthropy and Cultural Imperialism: the Foundations at Home and Abroad* (Boston: G. K. Hall, 1980).

⁴² Brown, p. 171.

Some trustees of the General Education Board, who favored the full-time requirement in principle, began to feel nevertheless that the policy of imposing specific form of organization as a condition for receipt of foundation grants was dangerous. It was not a question of whether the full-time policy was right or wrong but whether, in view of public opinion, the foundation could afford to pursue it. The protracted negotiations with Columbia added to the fear because, while Harvard's president and faculty "could be counted on to keep a gentlemanly silence about their conflict with GEB, the more volatile president of Columbia, Nicholas Murray Butler, was not adverse to spilling the beans."⁴³ As the conflict between Columbia and the Rockefeller foundations escalated, the Carnegie Foundation urged the officials of the General Education Board to abandon their strict full-time contracts.

Such a contract binding a university to a fixed policy laid down by the giver of money seems to me a dangerous thing. If these contracts were made public, I am sure it would bring down on all educational foundations no less than on the universities themselves severe criticism. It seems to me a dangerous policy for those who administer trust funds to adopt.⁴⁴

By 1925 this view was shared by the majority of the Rockefeller trustees as well. Only Gates and Flexner remained intransigent in their insistence of full-time contracts. Thomas Debevoise, who prepared the case against the old leadership, argued that explicit contracts were not only dangerous but unnecessary. "Most of the schools which receive money from the board come back at least a second time, and the possibility of their needing additional help should lend all the inducement necessary to make them follow the ideas of the board."⁴⁵ In 1925 the Board voted to modify the original contracts with Johns Hopkins, Vanderbilt, Washington, and Yale universities

⁴³ *Ibid.*, p. 172.

⁴⁴ *Ibid.*, p. 173.

⁴⁵ *Ibid.*, p. 174.

to allow them to deviate from strict full-time if they so desired and all subsequent contracts were free of binding requirements.

Profession and Class in the Full-Time Conflict

In 1925 the conflict over full-time clinical appointments was essentially over and a specific settlement over the claim to determine the institutional organization of academic medicine was reached, at least for a while. The battle over the full-time plan lasted for over a decade or, perhaps, much longer, if we take the long view of the emergence of scientific medicine in America. One of the final acts in this drama was played out in the boardrooms of Columbia, Presbyterian, and the Rockefeller foundations, although the particular institutional location is far less important than the records documenting the interests and strategies involved. The importance of events at Columbia reached far beyond its institutional walls, as, one after another, the terms of subsequent, as well as prior, contracts between corporate donors and recipient institutions fell in line with Columbia's model.

The conflict over the full-time clinical appointments was not, in its essence, a struggle between the foundations and the universities, nor did it pertain, as clinical faculty alleged, to academic freedom. Although the trustees and officers of the universities jealously guarded their powers against external imposition, their conflict with the foundations was over turf control and financial solvency, not fundamental conditions of academic work. This was not surprising because, not infrequently, the very same people who sat on the governing boards of the universities were also trustees of the foundations. As it became increasingly clear toward the end of the 'full-time' affair, both sides of the argument had support among the trustees of the universities and the foundations alike. Institutions, however, played a crucial role in structuring the positions of the adversarial groups that emerged during this conflict.

They did so not as particular organizations but as embodiments of a distinct, and ascendant, form of social production.

What was, then, the essence of the conflict that that played out so dramatically in the creation of Columbia-Presbyterian? Competing accounts that can be brought to bear on this question fall into two broad categories: those which view the process that restructured American medicine during the first quarter of the 20th century as basically consensual and those who see it as conflictual. Both functionalist and neo-classical economics perspectives, associated most closely with the work of Talcott Parsons and Kenneth Arrow, view the structural organization of medical care as a result of adaptation to either the society's functional needs or the uncertainty inherent in medical practice, respectively.⁴⁶ Resting on the assumption that, in the long run, social and economic organization tends toward functional stability and equilibrium, these perspectives tend to view social conflict as secondary to the process of rational adjustment. Consequently, the accounts of the evolution of medical institutions, which arise from within these perspectives, depict the interwar development of American medicine as a series of logical adjustments to social and technical requirements of modern medicine.

A more recent example of a consensual interpretation of the emergence of the full-time appointments in academic medicine can be found in Kenneth Ludmerer's magnificent history of American medical education.⁴⁷ Unlike functionalist and neo-classical economics perspectives, Ludmerer's argument by no mean denies the potential for significant conflict of interest between research- and practice-oriented segments of medical faculty or among other interests within the health care economy.

⁴⁶ Parsons, *The Structure of Social Action*; Kenneth Arrow, "Uncertainty and the Welfare Economics of Medical Care," *American Economic Review* 53 (1963).

⁴⁷ Kenneth M. Ludmerer, *Time to Heal: American Medical Education from the Turn of the Century to the Era of Managed Care* (Oxford: Oxford University Press, 1999).

Rather, Ludmerer stresses that the specific conditions, which prevailed during the interwar period, worked to balance and reconcile these potentially opposed interests. Consensual relationships, according to this argument, characterized both internal institutional relations and larger relations between academic medicine and society. The notion of public trust as a foundation of the profession's authority and privilege is central in Ludmerer's account and, during this period, he argued, the medical profession largely fulfilled its part of the social contract.

Both consensual and technical-rational accounts of the history of American health care do not stand close scrutiny. The former are belied by the historical evidence and the overall context of Progressivism and its aftermath, while the latter fail to explain why in other advanced societies modern medicine proved compatible with very different structure of health care provision.⁴⁸ Clearly, the account of the 'full-time' struggle presented above contradicts the consensual view of this period in the history of American medicine, whether rooted in a global view of social organization or in a historical analysis of contingent factors. Consensual interpretation is belied by the evidence of broad awareness of and sharp division over the issue within the medical profession at large, presented here and well-documented in other studies. Consistent ideological positions adopted by the opposed interests, combined with the amount of money involved, are hardly indicative of the trivial nature of the full-time conflict. The eventual settlement of the 'full-time' question, signified by the foundations' abandonment of outright requirements, should not obscure the intensity of the conflict that preceded it.

⁴⁸ Because Ludmerer's expansive history is executed in the style of a 'rise-and-fall' narrative, the temptation to underplay the negative and conflictual factors in the ascending part of the historical account and to overemphasize the same in the account of the fall may well account for his consensual reading of the interwar period.

Two characteristic features of consensual approaches tend to remove social conflict from view. First, by focusing on the relationship between specific features of health care organization and societal needs, they tend to overlook conflicts of the smaller scale and, perhaps more problematically, operate with a dubious and underspecified notions of ‘society at large’ and ‘societal needs.’ Second, consensual theories’ concerned with the long-term outcomes might systematically privilege resolutions of social conflicts over the actual processes of conflict which precede all such resolutions.

Conflictual accounts of the institutional development of American medicine have been advanced by scholars working with both Weberian and Marxist categories. One of the most prominent proponents of the former, Paul Starr argued that the structure which American medicine assumed during the interwar period reflected a temporary settlement in an extended social conflict.⁴⁹ During the first three decades of the 20th century, he contended, physicians consolidated and defended their position at the top of the medicine’s food-chain and accomplished a feat that few other occupations had: an “escape from the corporation.” For Starr, the specific form which American medicine assumed during this period was far from a logical outcome of functional and technical requirements of medical care, nor was it uncontested. The multiple advantages, which the organized medical profession secured its members, were attained through vigorous struggle against multiple adversaries and vigilant guard against encroachments. By the early 1930s, the medical profession emerged more powerful and more autonomous than ever before vis-à-vis corporate rationalizers, Progressive reformers, public health, hospitals, the states and just about any other force that endeavored to interfere with physicians’ prerogative to engage in

⁴⁹ Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982).

solo practice and to set their own fees. While the medical profession engaged in a number of public battles during this time, its ultimate achievement consisted in suppression of significant social opposition to its goals through extension and strengthening of its cultural authority.

The hallmarks of the Weberian approach to the analysis of medicine and health care – emphasis on profession as a primary unit of social process and cultural authority as its main instrument of social struggle – are unsupported by the present analysis of the ‘full-time’ affair. As to the professional unity, it is clear that the ‘full-time’ conflict both stemmed from and reaffirmed significant divisions within the medical profession and, therefore, cannot be adequately theorized in a framework that privileges profession as a primary unit of social politics of health care. Even before the ‘full-time’ struggle commenced, significant conflict of interest already divided professional elite from mainstream physicians, specialists from generalists and urban from rural practitioners. While all of these divisions stemmed in varying degrees from the differential access to institutional resources, none were as clear-cut in structural terms as those between clinical and non-clinical medical faculty. Not surprisingly, all of them declined in significance during the three decades after the World War II. In contrast, dissimilarity in the positions of the clinical and non-clinical faculty were so unambiguous that even in the 1930s the trend toward the disappearance of medical graduates from the basic science departments and their replacement with Ph.D.s from liberal sciences was quite evident. It would be hard to find a clearer indication of a radical distinction between the two segments of what is nevertheless considered a unitary profession.

The crucial distinction between clinical and non-clinical segments of academic medicine must be theorized in terms of class. The essential difference between the two groups parallels the distinction between the old middle class of small proprietors

and businesspeople and the new middle class of credentialed educated employees who sell their labor at a premium. In this sense, non-clinical medical faculty has more in common with the liberal arts and sciences faculty than with private physicians. Arguably, the position of non-clinical faculty is more comparable with that of the technical professionals employed by private corporations, insofar as both of these groups cannot sell their services directly to the consumers. It is not surprising, then, that in the 'full-time' conflict the laboratory faculty sided with the foundations, whose policy, as I argued in previous chapter, was formulated by and from the point of view of the salaried corporate professionals.

Consideration of the institutional position of the medical faculty in basic science departments explodes the myth of the uniform antagonism between professionalism and bureaucracy, the characteristic trait of modern institutional organization. Both the scientific faculty and the leaders of the medical profession irrespective of their field were well aware that scientific medicine was rooted in research and that the latter required, as its pre-condition, a high degree of institutional centralization and external investment. It was abundantly clear that the financial resources of the profession itself would not suffice to underwrite either medical research or education on the level of the leading European countries. During the first decades of the 20th century, American state was not yet a viable source of massive investment in private education and research. Corporate wealth, therefore, constituted a principal potential source of funding of scientific medicine. Corporate organization, just as much as corporate wealth, was an acknowledged necessity for systematic scientific progress. By the turn of the 20th century, leading American hospitals and universities were already restructured on a corporate model and, thus, provided logical institutional anchoring for scientific medicine.

Non-clinical medical faculty members were as loyal to institutional structure of medicine as their clinical colleagues were ambivalent about it. In the 'full-time' struggle, however, the latter had the support of the large portion of the medical practitioners who, by virtue of their exclusion from institutional privileges, were outright antagonistic to the institutionalization of medicine. This factor, combined with numerical weakness of the non-clinical faculty and internal institutional problems of the foundations, offers a far better explanation of the full-time affair than that which credits the purported unified front put up by the medical profession against institutional rationalization of medicine.

Starr's emphasis on cultural authority as the primary instrument of professional dominance is just as problematic as his insistence on professional unity. He defined cultural authority as a surrender of private judgment and assumption of deferential cognitive posture by patients and lay public of all classes. Leaving aside the question of how much authority patients actually granted medical practitioners, it is clear that in the post-Flexnerian era, the foundation managers, as well as other educated reformers and donors, hardly conceded to doctors the authority on the issue of how best to organize medical care provision. Medicine's new scientism failed to impress the lay reformers who viewed American medical profession as provincial and petty. In fact, many lay reformers believed that much credit for modernizing American medicine justly belonged to those outside of the profession.

Rhetorical fight between the clinical faculty and the foundations was waged over the territory not automatically considered physicians' cognitive prerogative. The question was not how to perform surgery or diagnose disease but how to organize medical practice, education, and research so to optimize their contribution to social welfare. In this matter, economists, sociologists, educators, or statesmen might have well claimed to have more expertise than physicians. This is not to say that physicians

easily gave up their claim to be the best judges. In fact, professional leaders often claimed special expertise in the matters of professional organization and functions. But creative they were not, repeating one and the same cry that no program, policy, or plan was acceptable unless it respected the professional sovereignty of physicians, by which was understood preservation of the institution of private solo practice. Not surprisingly, lay reformers accused physicians of commercialism and viewed them as a significant part of the problem with medical care itself.

The concept of cultural authority, advanced by Starr, closely resembles a dichotomy between expert physician and lay patient which has been at the center of interactionist sociology of medicine and comes as a surprise from a structural sociologist. This dichotomy, anyway, works best to explain encounters between doctors, who uniformly belong to the educated middle class, and patients from lower-class backgrounds and with low educational achievement. As Starr himself insists, lower-class Americans did not have much influence on the organization of medicine.⁵⁰ It is clear, then, that most of the struggles over institutional structure of medicine were waged among the various middle- and upper-class groups, which is to say, among peers, in cultural terms at least.⁵¹ This does not mean that cultural authority, rhetorical strategy, and ideological obfuscation had no place in these social negotiations: after all, the members of the professions may well be the choice victims of their own ideologies.

Conceptualization of medicine's modernization in terms of the profession's cultural authority is challenged not only by the evidence of opposing discourse of its lay opponents but also by the inherent dualism in the structure of modern professional knowledge. Conventional sociology of the professions has for a long time maintained

⁵⁰ *Ibid.*, p. 232.

⁵¹ Larson, p. 157.

that the special character of professional expertise, encompassing both considerable technical complexity and inherent uncertainty, underpinned professional autonomy and privilege. In their path-breaking analysis, Jamous and Peloille argued that, far from being a constitutive factor of professional autonomy, systematized scientific knowledge provides an opening for external intervention and regulation of professional work.⁵² Inherent in the structure of modern professional knowledge, they argued, is a duality of ‘technicality’ and ‘indetermination.’ Technicality refers to a rationalized and transferable body of knowledge which serves as a basis of professional efficacy and continuity, insofar as it can be communicated as a set of rules, procedures and solutions among contemporaries and from one generation to the next. While such systematization and transferability of professional knowledge provides a basis for legitimation and certification of professional expertise, it also exposes professional work to codification, fragmentation, and routinisation. Thus, the trend toward greater codification of professional knowledge and creation of more technical means of production increase the possibilities of intervention.⁵³ The concept of ‘indetermination,’ on the other hand, refers to the intangible ‘virtualities’ of the profession – the “bases of its mystique, the sources of its legitimation, and the elements of its ideology” – all of which act as barriers to external intervention and, therefore, underpin the profession’s monopolistic position.⁵⁴ In this sense, indetermination is not an aspect of knowledge but, instead, an aspect of the occupational control of knowledge.

⁵² Haroun Jamous and Bertrand Peloille, “Professions or Self-Perpetuating Systems? Changes in the French University Hospital System” in J. A. Jackson, ed., *Professions and Professionalization* (Cambridge: Cambridge University Press, 1970), pp. 110-152.

⁵³ *Ibid.*, p. 142.

⁵⁴ Terence Johnson, “The Professions in the Class Structure,” in R. Scase, ed., *Industrial Society: Class, Cleavage and Control* (New York: St. Martin’s Press, 1977), p. 99.

Different rhetorical strategies adopted by the adversaries in the ‘full-time’ conflict are consistent with the Jamous-Peloille thesis of the dualistic character of professional autonomy. The foundations, as well as other lay advocates of medical reform, stressed the ‘technicality’ of professional knowledge. While they did not claim to possess physicians’ skills, the lay reformers insisted that, as intelligent and educated persons, they were perfectly qualified to understand and improve the organization of medical work. Instead of rendering medicine less accessible to lay understanding, scientific medicine actually clarified to the lay philanthropic reformers how the optimal gains to public health could be achieved.

Not surprisingly, the opponents of full-time clinical requirement resorted to the arguments stressing the aspects of ‘indetermination’ in medical practice. Osler, among others, stressed that medicine was an art, as well as a science. The official statement produced by Columbia’s clinical faculty against ‘full-time’ was a superb exercise in elaborating the profession’s subtle virtues and relied on a predictable dichotomy between the futility of “restrictive rules” of institutional organization, on one hand, and the “true spirit of service” which could be guaranteed only by recruitment of the “right men,” on the other. Professional excellence stemmed from intangible embodied qualities of the professionals themselves and had nothing to do with the crude technical prescriptions of institutional engineering. ‘Taylorist’ science, insisted Columbia’s clinicians, did not apply to professional work.

In contrast, the position of the foundations’ managers turned on a ‘technical’ view of scientific medicine. The greatest promise of medical science lay in discovery of the foundational causes of disease and measures to prevent it. It is true that both of these goals were understood mostly in bio-physical terms. There was, nevertheless, a pronounced social-scientific bend to the foundations’ stance as well. The foundations’ leaders understood medicine as a social, rather than private function and sought to

optimize its public benefits through rationalizing the social organization of production of medical research, education, and care. It is interesting to note, however, that, unlike the more successful attempt to rationalize health care, launched by state and corporate interests during the early 1980s, the corporate-philanthropic efforts during the 1920s had virtually no foundation in the university or governmental research establishment. As academic fields, both public health and administrative medicine were in their infancy. More significantly, both were shunned by physicians and weakly claimed by nurses, public health officials, and hospital administrators, shaping up to be the educational fields of the subordinate professions with weak graduate component. Consequently, the lay medical reformers were drawn from a variety of social science disciplines and professional careers, many of which were caught in the middle of their own professionalizing projects. Loosely organized by such singular institutions as the Rockefeller Institute for Medical Research, philanthropic boards and civic organizations like the Committee of One Hundred, their numbers were few and the ‘technical’ component of their reform agenda was weak. Although they passionately believed in the rationality of their analyses and proposals, in truth, they lacked the principal institutional and professional means of furthering the technocratic approach to the problem of medical care. Not until the 1980s were such means to materialize in the form of specialized academic disciplines, governmental agencies, and corporate analysts.

In contrast to the proto-social-scientific discourse of the foundations and other lay reformers, the basic science faculty elaborated the argument for medicine’s ‘technicality’ from within the new discourse of scientific professionalism. Actively attuned to the full-time conflict, scientific faculty saw their work in both technical and productivist terms. Medical scientists, insisted one prominent physiologist, ought to “remodel the whole system so as to fight disease at its source. ... Surely it is a time

when those who have laid the scientific foundations for the new advances should take counsel together, assume some generalship, and show how the combat is to be waged.”⁵⁵ Academic physicians in laboratory sciences, as well as handful of those clinical scientists who strongly preferred research and teaching to private practice, believed that the credit for the modern medicine’s effectiveness belonged to those who labored in laboratories and on the hospital wards. Private physicians, on the other hand, were in the business of selling the new cures to paying patients. In what must have surely seemed like a sad irony to the medical scientists, private practitioners reaped much higher material rewards than they. Much like class-conscious workers saw their plight, medical scientists felt exploited in the prevailing system. They did not, however, advocate abolition of the corporate organization of production. In fact, they proposed to extend it to include all medical faculty or even all physicians. The faculty in the basic science departments clearly understood that their work was inextricably bound to modern organizations and their ideological position reflected the de facto institutionalization of their work. Like corporate-philanthropic rationalizers, medical scientists saw the collectivized, institutionalized system of production, reflected in the structure of modern university, as an expression of technical rationality. The main problem with this organization, as they saw it, lay in the disproportionate power of the clinical faculty who were not even fully incorporated into either the university or the hospital organization. In the context of the ‘full-time’ conflict, the interests of the non-clinical faculty were to equalize the institutional position and, therefore, the material interests of all medical faculty. For this segment of the new middle class, the problem of leveling the class position called for an institutional solution.

⁵⁵ Brown, p. 163.

Theorized in the framework of institutional class analysis, the socio-economic character and distinct interests of this segment of the medical profession differ from those put forth in Marxist accounts of American medicine. Scholars writing from within the Marxist tradition argue that the provision of medical care in capitalist societies is subject to fundamental, rather than contingent, social conflict and is overwhelmingly determined by the interests of the dominant class. Although clearly an instance of class struggle, interpretations of the full-time affair and related developments offered by Marxist scholars fail to capture the complexity of the historical process. E. Richard Brown, whose work is especially germane to the period and issues explored here, viewed the full-time affair as an opening act in the struggle to subordinate medicine and the medical profession to the interests of the ascending corporate capitalist class. It is hard to agree with Brown's overall conclusion that, notwithstanding the abandonment of the full-time requirement, corporate capital succeeded through its philanthropic foundations in subordinating medicine to its hegemonic class interest. In regard to the outcome of the full-time struggle, we must side with Paul Starr's conclusion that, despite their considerable resources, the foundations' success in rationalizing medical care was quite limited.⁵⁶

While Brown's analysis of the differences between clinical and non-clinical faculty is quite astute, his insistence on the identity of interests between corporate capital and medical scientists and his overall class analysis of the philanthropic foundations and their leaders are less than convincing. These problems are, to a large extent, the two sides of the same coin: what Brown misreads in both instances is the identity and interests of the new salaried middle class, to which belong both the medical scientist and the foundation manager. While the ideological convergence

⁵⁶ Starr, p. 17.

between the foundations and the laboratory scientists makes a lot of sense, their reduction to the interests of the capitalist class is surely an oversimplification born out of inexorable attraction of Marxist scholars to binary or totalizing accounts of social organization.

The leaders of both Rockefeller and Carnegie foundations believed in the enormous social value of scientific medicine and were outraged that the narrow commercialism of the medical profession stood in the way of extending medicine's benefits to all. Moreover, foundations' managers maintained that the greatest promise of modern medicine lay in preventive rather than curative measures and aimed to reorganize American medicine toward that end. Curiously, these views bore the greatest similarity to those of socialists, while neither labor leaders, nor capitalist employers shared this enlightened stance to any significant degree. To this author, this suggests the possibility that the foundations' strategy reflected most closely the interests of their managers, rather than founders.⁵⁷ It will be recalled that the key figures among the foundations' managers came from middle- and even lower-middle class backgrounds. But more important than the socio-economic origin may be the particular function with which they were entrusted, namely, to disburse philanthropic funds in a way that would promote rationalization of key social spheres. As such, the foundations' managers occupied a position similar to the executive officers in the non-profit sector.

A theory of the middle class professions arrived at by Johnson via the work of Jamous and Peloille, as well as Carchedi, allows us to move from an intuitive apprehension of the ambiguous class position of the salaried middle class to its

⁵⁷ On the problematic relationship between socialism and the intellectual class, see Andrew Milner, *Class* (London: Sage Publications, 1999).

theoretical specification.⁵⁸ Carchedi argued that in the advanced stages of capitalism the functions of both labor and capital become subdivided into specialized operations, dispersed among different categories of workers. Under the system of production increasingly reliant on application of science and technology, the work of educated credentialed employees, traditionally considered unproductive in Marxist theory, becomes productive, insofar as it involves mental labor of technical character and contributes to the production of surplus value.⁵⁹ Just as productive labor comes to encompass a wide range of specialized work functions – both mental and manual – so the global functions of capital are delegated to agents who do not formally own the means of production. This process involves the development of a complex organizational structure which collectively performs what during the competitive stage were the functions of the individual capitalist. Following Carchedi, Johnson views middle-class professions as being, in varying degrees, agents of both the collective laborer and global capital. They are, then, “part of a class which carries out the global functions of capital without owning the means of production ... while at the same time and in various ratios carrying out the functions of the collective laborer – they are then both laborer and non-laborer, exploited and exploiters.”⁶⁰

It is not difficult then to see why the ideological motifs traditionally associated with socialist and working-class interests may be found in the rhetoric of the institutionalized middle class professionals. Insofar as a significant portion of their labor becomes subordinated to organizational imperatives of the institutions, directly or indirectly controlled by corporate capital, these middle class employees may well reach for ideological arguments that most often come from the lower rungs of the

⁵⁸ Jamous and Peloille, “Professions or Self-Perpetuating Systems?”; Guglielmo Carchedi, *On the Economic Identification of Social Classes* (London: Routledge and Kegan Paul, 1977).

⁵⁹ Johnson, *Professions and Power*, p. 103.

⁶⁰ *Ibid.*, p. 104.

occupational hierarchy. In the context of the university, where middle class academics are not as obviously involved in the exploitation of the working class people as some of their colleagues in corporate management and industrial production, an attenuated version of the call for control of production by direct producers may be a viable rhetorical strategy in certain circumstances. This potential affinity between the interests of the institutionalized middle class employees and ‘productivist’ ideology of the working class explains some of the rhetorical positions adopted by both medical scientists and foundation managers in the ‘full-time’ conflict.

However, the extent to which the salaried middle class may be willing to adopt progressive ideology is clearly limited as long as their privileged position in the division of labor is sustained. While Carchedi is correct in asserting that, in the framework of corporate capitalism, the mental labor of the credentialed employees is productive, its productivity lies in what Jamous and Pelloille identify as ‘technicality’ of professional function and not, as both Carchedi and Johnson seem to suggest, in the functions of “co-ordination and unity.” Separation of mental and manual labor always already presupposes deskilling and, hence, exploitation, of the manual workers and any of the functions of “co-ordination and unity” that the middle-class employees might perform are the veiled directives of the collective capitalist.

Defense of precisely this privileged position in the social division of labor served to lessen the conflict between the clinical faculty, on one hand, and the non-clinical faculty and the philanthropic foundations, on the other. In varying degrees, representatives of all three groups subscribed to the belief that their privileged occupational and economic position stemmed from the meritocratic system of social selection and the imperatives of rational social organization. In the context of growing institutionalization of all spheres of production, this view implied a shared interest of the middle-class professionals in expansion and rationalization of the hierarchical

principles of corporate organization. In the context of academic medicine, all parties to the 'full-time' conflict agreed that, to speed up medicine's progress, physician-scientist should be provided with all administrative and technical assistance necessary to free his time for scientific work of the highest order. This goal received much attention in Dean Darrach's memorandum and in writing of academic leaders at large.

The more centralized and hierarchical organization achieved at the leading medical centers has by itself accomplished a large part of rationalization sought by the foundations. Even though the clinical faculty retained the right to engage in private practice at their discretion, during the first quarter of the 20th century the cumulative changes in the organization of academic medicine greatly increased the proportion of official or de facto full-time employment in the professional and academic departments of the medical centers. All residents, as well as many junior faculty members who were yet to develop significant private clienteles, worked on a full-time basis. While retaining private patients, top clinical faculty were also devoting a much greater proportion of their time to their academic duties. This latter change resulted not only from voluntary limitation of private practice but also, no doubt, because of growing ability to devolve basic tasks to their subordinates.⁶¹

During this period, hierarchical centralization significantly strengthened the position of the departmental chairs and was, therefore, actively supported by the top faculty in both clinical and non-clinical departments. At Columbia-Presbyterian, however, centralization had also reinforced the dominance of medicine and surgery

⁶¹ One other factor tended to lessen the conflict over the full-time appointments at Columbia and at other medical schools as well. While technically a basic science department, pathology, for instance, accorded an opportunity for its faculty to earn patient fees. Early organization of laboratory work at Presbyterian, as well as in other hospitals, allowed physicians who performed the tests to charge patients. Consequently, although their general professional outlook was very much in line with science faculty, some physicians in the departments of bacteriology, pathology, and radiology derived part of their income from patient care and, as a result, were reluctant to oppose private practice privileges of their clinical colleagues.

over other disciplines and marginalized laboratory science faculty in institutional governance. In the atmosphere of massive resignations and new appointments which marked the process of affiliation, new clinical leadership seized an opportunity to create at the Presbyterian Hospital an organizational structure quite different from that of the P&S and, in principle, contrary to the general trend toward specialization and growing importance of basic science. While the number of academic departments of the Medical School was increasing, the reorganization of the Presbyterian professional staff reduced the number of all in-patient services to three: medicine, surgery, and pathology. Their directors were constituted as the Medical Board which remained a three-man body until its reorganization in 1922.⁶² The dual institutional grounding of the academic-professional staffs – in the university and in the teaching hospital – allowed the dominant departments to create and utilize two different structures of authority in a way that favored their interests. Although the full-time conflict appeared to center around the University, it was managed through the Hospital-based governing structure of the Medical Board which did not fairly represent the interests of the non-clinical departments of the medical school.

⁶² The reorganization was initiated by Dr. George E. Brewer who replaced Dr. Blake as head of the First Surgical Division in 1914. Dr. Brewer accepted the appointment on certain conditions which brought about the restructuring not only in surgery but in all departments of the Hospital. As a result of his requests, the staff was divided into three Services: Surgical, Medical, and Pathological. Director of each service was to have absolute control over the patients under the care of his department and the authority (which up until then was vested in the Superintendent) to suspend from duty, subject to later decision of the Managers, any member of attending, house, or outpatient clinic staffs for action “prejudicial to the interests of the Hospital or to the welfare of a patient.” [Lamb, p. 86.] The three-person Medical Board, which emerged as part of this reorganization, was clearly too small to represent the various interests of the medical staff. Nevertheless, it has persisted in this form for over seven years until, in January of 1922, the Medical Board was enlarged to include ten voting and two ex-officio members. The new arrangement was still clearly dominated by medicine and surgery who had six representatives on the Board and whose directors were automatically occupied the posts of the President and Vice-President of the Board in turn. Pathology had two representatives on the Board and bacteriology and dentistry had one each. [Lamb, pp. 200-201.]

The Aftermath of the Full-Time Struggle

While the foundations failed in their project to rationalize the provision of medical care in society at large, they succeeded, for the most part, in modernization of the medical education and research. Most medical schools, which the foundations deemed strategic, were restructured to provide high-quality medical education and to conduct impressive volume of research. The initiation of massive federal investment in medical research after the Second World War reinforced the gains made by corporate philanthropies. For the next two decades, advancement of medical research emerged as one of the top public priorities and the amount of federal funding channeled toward that end made it the ‘golden age’ of American medical research. At the academic medical centers, research became the predominant force of institutional growth and the leading medical schools were transformed into veritable centers of medical research. At the same time, teaching hospitals and clinical staff continued to develop their private and semi-private patient services which continued to be important sources of hospital revenue and clinicians’ income.

The balance between the medical centers’ academic functions and commercial services began to unravel after the early signs of Medicare’s fiscal crisis. To stem the tide of rising health care costs, in the early 1980s the federal government began experimenting with a series of cost-cutting mechanisms in the system of Medicare reimbursements. A decade later, cost-management measures were widely adopted by private insurance industry. Unlike the original Medicare, the new public and private systems of reimbursement did not give recognition to the necessarily higher costs of teaching hospitals associated with their function of training the future physicians and forced the medical centers to compete with non-teaching hospitals and clinics on an equal basis.

Squeezed from all sides by shrinking profit margins from clinical practice and diminished federal research grants, American medical centers adopted a market-based approach to institutional survival. Clinical services were expanded again, although this time with little hope of substantial cross-subsidy of the medical center's educational and research mission. Shrinking profit margins of clinical services plunged medical centers into the competition to raise clinicians' productivity, capture more profitable patients, and expand the volume of services. The medical centers' adjustment to the managed care system of health care financing prompted a wave of vertical integration with outlying community hospitals and clinics, motivated exclusively by the need to improve clinical revenues. If during the late 1960s and 1970s the explosive growth of the medical centers' involvement in provision of clinical services distracted much of their attention from education and research, at least it was reimbursed generously enough to subsidize them. Now, clinical services had to be expanded simply in order to preserve the medical centers' clinical facilities in an ultra-competitive environment, with little hope of substantial cross-subsidy of the medical center's educational and research mission.

Ever since the 1920s, when academic physicians fought to preserve their stake in private practice, medical centers were compelled to expand their involvement in care of private patients, both to allow their faculty members to enjoy higher incomes and to use a part of the profits to support institutional purposes. In the 1980s and 1990s, when the medical centers' hypertrophied clinical services were occupying more and more of their human and financial resources, while giving little back to education and research, the ultimate price of that fateful choice was becoming apparent. With a slowed growth of federal support, the maintenance of the enormous research capacities, built up after the war, required new methods of financing. In a radical break with traditional tenets of academic ethics, medical centers and individual

investigators began to accept corporate sponsorship in exchange for patent rights to their intellectual work and to form their own for-profit biomedical research companies. Although, through these and other methods, the medical centers stayed afloat, all three elements of their original mission – charitable care, medical education, and scientific research – may have suffered permanent damage through their ruthless exposure to the strictures of the market.

CHAPTER 4

BUILDING THE FIRST MEDICAL CENTER: CONFLICTS OVER PHYSICAL SPACE AND INSTITUTIONAL PURPOSE, 1922-1945

Introduction

The enormous task of building the nation's first university medical center was an occasion to examine the organizational structures and functions of the two institutions that were about to tie their destinies in a common physical space. Financially and logistically daunting, the construction of the Columbia-Presbyterian Medical Center revealed divergent priorities among the different groups involved in the project. One of the most visible conflicts during the construction phase concerned the outpatient department (OPD), a vital service to the poorer urban residents that had been and continues to be one of the weakest links in the American system of health care services. From a thirty-two-story air castle imagined in the early construction plan, the outpatient department was quickly reduced to the one-and-a-half-story joke and the very last item on the funding priority list. The struggle for the adequate OPD revealed both the different interests within the Medical Center and the different logic of institutional responsibilities and resource allocation deployed by opposed groups.

Far from settling organizational conflicts, the completion of the Medical Center brought on the new challenges of adjusting the new physical spaces to the evolving demands of patients, educators, and doctors. The problem of providing adequate yet differentiated services to the so-called 'semi-private' patients was especially acute in the newly built Medical Center. Despite a serious effort to study the problem and propose a solution, Columbia-Presbyterian failed to address the 'semi-private' question either in terms of physical accommodations or by way of

novel financial arrangements. The conflict over the 'semi-private' patients pitched the professional interests of the younger physicians and demands of the community against the resistance of the professional and administrative staffs as a whole.

From the outset, Columbia-Presbyterian presented a breathtaking endeavor: over a dozen hospitals, institutes and clinics, as well as the medical, dental, and nursing schools coming together to recreate themselves as a unified center. But the actual reach of its activity was even farther than its physical campus would suggest. During the first two decades of its existence, the Center affiliated with a dozen other institutions, while continuing to bring others to its site. Its relationship with public institutions was especially noteworthy, often involving not only clinical instruction of students but the nomination of professional staff as well. The pattern of relationships created both within and beyond the Center reflected a complex structure of professional hierarchies and social connotation of disease, revealing interrelationships among private institutions and between private and public spheres.

The creation of the physically unified Medical Center opened as never before the question of the ultimate purpose of such an institution and the best way in which it could be achieved. A survey of the key statements of purpose produced during the first two decades of Columbia-Presbyterian's existence highlights two broad perspectives: that of community service and that of balanced facilities necessary to carry out the task of medical education. While the rhetoric of 'community service' was quickly tethered to the primary purpose of educating future physicians, the primacy of the educational mission was also something of a myth, contradicted by divergent interests and organizational developments.

The issues of institutional structure and purpose, which emerged during and after the construction of the Columbia-Presbyterian Medical Center, point toward a number of common conclusions. Institutional conflicts were structured along the lines

of what I call ‘institutional class positions,’ rather than more commonly recognized professional and organizational divisions. Institutional class positions of health care providers were significantly linked with class, race and other salient social divisions among patients. Public and private structures of health care provision were vitally, if hierarchically, linked, each constituting an institutionally organic part of another. Taken together, these conclusions emphasize the larger arguments of this dissertation, namely the call for a combined study of the public and private structures of social provision and the need for new theoretical perspectives on the structure of health care politics.

Struggle for the Out-Patient Department

Outpatient services have been long-standing, yet particularly troubled parts of America’s private hospitals. The outpatient department of the new Columbia-Presbyterian Medical Center was no exception. The new department was to combine the budgets, staffs, and traditions of the two previously separate entities – Presbyterian Hospital’s Out-Patient Department and Columbia Medical School’s Vanderbilt Clinic.

Presbyterian’s outpatient department had its roots in the Dispensary which was built as a part of the Hospital’s first major expansion. The building was made possible by Miss Henrietta Lenox, the Hospital founder’s sister, who offered to give \$50,000 if other friends of the Hospital would match this sum. The Dispensary opened in 1888, when the Hospital was in its sixteenth year of operation, and by the end of the first year it served an average of 38 patients a day.¹

Columbia Medical School’s outpatient clinic was one of the gifts of the Vanderbilt family, the School’s chief benefactors during the late 19th century. The plot of land and the money for the construction of the new buildings to house the

¹ Albert R. Lamb, *The Presbyterian Hospital and the Columbia-Presbyterian Medical Center, 1868-1943* (New York: Columbia University Press, 1955), pp. 35-36.

College of Physicians and Surgeons, as the medical school was officially called, were given by the patriarch of the family, William Henry Vanderbilt, in 1884. The Vanderbilt Clinic was given by his three sons in the memory of their father after his death. In 1886, Vanderbilt's daughter and son-in-law, Emily Thorn and William D. Sloane, offered to erect and endow on the College grounds "a lying-in asylum to be known as the Sloane Maternity Hospital of the College of Physicians and Surgeons."² Vanderbilts' beneficence toward the school came about through the influence of Dr. James McLane, a family physician to the Vanderbilts and member of the College's faculty.

Like most urban dispensaries of the time, Presbyterian's was a rough institution, challenged by the surging demand and limited resources. The Hospital's chief historian, who was personally involved with the Dispensary for a long time, recalled that

[a]lthough it gave valuable attention to thousands of patients each year, as late as 1911 Presbyterian's Dispensary was not well organized. There were almost no records of histories or of physical examinations; records that were made generally contained nothing more than a note of the medication ordered. Cooperation with the inpatient service was weak and the follow-up system covered only a portion of patients. Many of the doctors were lax in attendance, coming late or leaving early to see some private patients, often not appearing at all.³

According to Dr. Lamb, significant changes in this state of affairs were affected soon thereafter. At this time, departments of medicine and surgery conducted separate out-patient clinics and improvements were first achieved in the latter when Dr. Hugh Auchincloss was appointed Surgeon-in-Chief. "With great effort and skill,

² Harold Speert, *The Sloane Hospital Chronicle: A History of the Department of Obstetrics and Gynecology of the Columbia-Presbyterian Medical Center* (Philadelphia: F.A. Davis Company, 1963), p. 3.

³ Lamb, p. 97.

he gradually converted his clinic from one of scantily recorded minor surgery into a model clinic with an excellent staff of assistants, adequate records, and a follow-up system.” As a result of these improvements, “members of his staff found the opportunity for genuine accomplishment, and many of them began to do work in their individual fields of interest right there.”⁴

In 1913, the surgical and medical clinics of the Dispensary were combined into a single Out-Patient Department and a year later reorganization began at the medical half of the clinic. Appointed Physician-in-Chief at the OPD, Dr. Lamb received a valuable advice from an outgoing head of the medical clinic. “Don’t try to force any of the staff out,” he was told, even the bad ones. Instead, “[m]ake the work so thorough and interesting that the good men will see the advantages and enter into the work wholeheartedly [and the] others will naturally drop out.”⁵

Working in cooperation with Dr. Neergaard, Dr. Lamb gradually succeeded in reorganizing the medical clinic along the lines established by Dr. Auchincloss in surgery. As early as 1915, the out-patient department of the urban hospital already revealed the essential dilemma at its core: to raise the quality of service, the quantity of patients served had to be reduced. Under Dr. Lamb, it was decided to limit the number of medical admissions into the OPD to those who could be adequately treated with the available staff and facilities. It was also noted that many medical cases, for whom admission into the hospital wards had been arranged, never checked in. To remedy this situation, the follow-up measures were intensified and thereafter some 95 percent of such patients actually entered the wards. Upon discharge from the hospital, patients were given a specific appointment at the OPD and about 94 percent complied. As a result of these changes, definite information was obtained on over 2000 patients

⁴ *Ibid.*, p. 97.

⁵ *Ibid.*, p. 98.

or 91 percent of the total. According to Dr. Lamb, “[s]uch data was and remains crucial in evaluating operative results and treatment methods” and Presbyterian’s follow-up system was adopted by twelve other hospitals.⁶

The early efforts at improving the outpatient service revealed a number of themes. The hospital dispensary could not succeed as a pure service institution. Both the ethic of service and a suitable class of workers who could be swayed by that ethic were absent. Rather, the OPD served the professional interests of the larger hospital. This relationship was primarily effectuated by the OPD’s function of feeding the wards with suitable and interesting cases. Secondly, the OPD could – with proper organization and improvements – serve as a field of medical research and training in its own right. Only if tied with the professional interests of the hospital’s physicians could the outpatient service function adequately. Even so, the generalized interest in using the OPD as a feeding pipe of interesting ward material did not dictate anything beyond the most basic triage and service arrangements. It is only the more specific interests of the younger, less successful physicians who were assigned to serve at the OPD that could effect the badly needed improvements. This explains the frequent theme of strengthening the OPD’s research value. Only if OPD physicians could leverage their unpromising clientele into training and research pool and the OPD as a whole into career stepping stone, would significant changes be affected.

Additional personnel and equipment, as well as better management of patients, could also make a significant difference. In 1921, for example, Presbyterian’s OPD became involved in the larger project. As part of the initiative of the Dispensary Development Committee of the United Hospital Fund and with the financial support

⁶ *Ibid.*, p. 98.

of the Rockefeller Foundation, Presbyterian Hospital agreed to designate its OPD as a demonstration unit. According to Dr. Lamb,

The whole project, which looked to the improvement of out-patient work in general, was successful over a considerable period. Miss Elsie Jameson, a clinic executive, was very helpful in relieving the chief of clinic of much administrative work. Additions were made to the clerical force, new equipment was acquired, closer cooperation between the O.P.D. and the wards was effected, and discharge clinics were established. These improvements and the fact of being selected as a demonstration unit showed how far the O.P.D. had progressed from the days when it had been regarded as an unimportant appendage to the Hospital and service there as tedious drudgery. Those of us who had believed that the O.P.D. could be developed and could be of service to the Hospital and the community – mainly Dr. Hugh Auchincloss, Dr. Arthur Neergaard, and I – now felt doubly rewarded for our work with it.⁷

The addition of a new female administrator and clerical workers filled the lack of suitable ‘service’ layers in the structure of the OPD. These staff additions could relieve the higher-class, male physicians from those tasks which did not constitute direct investments in career advancement.

The next pivotal moment in the history of Presbyterian’s and Columbia’s outpatient departments came with the building of the Columbia-Presbyterian Medical Center. Construction plans got underway in 1922. An architect and a builder were secured and Dr. Clarence Charles Burlingame was made Executive Director of the Joint Administrative Board, which had the responsibility of formulating the construction plan. During his varied career, Dr. Burlingame had inspected many hospitals in the US and accumulated an enormous amount of data valuable in the planning process. Several other members of the Hospital and the University had also visited various hospitals and medical schools in preparation for the construction planning. The most comprehensive trip had been undertaken by Dean Darrach, who

⁷ *Ibid.*, p. 171.

had gone abroad in the summer of 1921 and visited some seventy-three hospitals and twenty-eight medical schools.⁸ Another important appointment during this period was that of Mr. John Bush as the Hospital's superintendent. Until this time, almost all hospital superintendents – at Presbyterian and elsewhere – were either doctors or ministers. Mr. Bush was a businessman and it proved the most fortuitous innovation as Presbyterian embarked in reincarnating itself in a new Medical Center.

Despite all the appointments and activity, little progress on actual planning was achieved. Despite his broad experience, Dr. Burlingame's approach to the task of planning struck many as "mystifying." Plan after plan produced by the architect and the builder were rejected. Dr. Lamb's account of the state of planning in 1923 painted a sorry picture.

An informal dinner meeting to discuss the project was held at the University Club on May 3. There was a large group present, including doctors and other official from the Hospital and the University. Many of them were getting their first glimpse of the proposed size of the Medical Center. The same layouts of thirty and fifty stories were displayed. When the question of cost was raised, no accurate estimate was attempted. Those qualified to give an approximate figure mentioned nothing less than fifty millions. This figure, of course, was staggering, and most of those present sense what John Bush had already detected: "Much time has been wasted in building air castles, and the whole subject has to be brought down to earth."⁹

When the planning process was finally forced into a more practical mode, it was clear that the size of most services had to be derived from the proposed extent of the teaching activities. "The size of Presbyterian's and Columbia's buildings – the nucleus of the Medical Center – would have to depend upon the size of the student body and teaching program of P. and S. Until this decision was made, no concrete

⁸ *Ibid.*, pp. 177-178.

⁹ *Ibid.*, p. 183.

plans could be formed.”¹⁰ University administration preferred a larger student body – about 125 to a class – for the greater financial return in tuition that would entail. Most faculty members preferred a smaller class size of 60 to 75 students for the sake of providing better education. The planners from the two sides settled on compromise: classes of 100 students each with a total student body of 400. It was estimated that the number of hospital beds necessary for teaching this number of medical students was about 500. This figure, in turn, helped determine the size of the outpatient department, “because it required a certain number of clinic patients to furnish a sufficient number for the wards.” The estimate, which was carefully derived from the experience of the old Presbyterian O.P.D. and the Vanderbilt Clinic, called for a facility capable of handling from 1,000 to 1,200 patients per day.¹¹

While the planning of the inpatient wards was soon accomplished in a more or less rational manner, the planning of the outpatient clinic encountered a different fate. Dr. Lamb recalled a meeting at which he and Dr. Auchincloss were present.

We met with the Planning Committee of the Joint Board one afternoon to discuss the structure of the new O.P.D. Dr. Burlingame announced that a building of thirty two stories was proposed. Dr. Auchincloss and I were astounded. Even as we caught our breath, Dr. Burlingame went on to state that eight of the floors were being planned for dentistry. I had to comment that such a scheme was impracticable and entirely out of balance with a proper clinic. We were brusquely informed that we were not competent to decide such matters. We had no recourse except to remain silent though I was sure of my stand and though a thirty- two-story building smacked of the air castles earlier envisioned.¹²

As Drs. Auchincloss and Lamb had suspected, the air castle of thirty-two stories collapsed very soon. After a serious financial crisis, which had been barely

¹⁰ *Ibid.*, pp. 184-185.

¹¹ *Ibid.*, p. 185.

¹² *Ibid.*, p. 188.

averted, as well as predictable overruns on construction costs, only \$600,000 were allocated for the outpatient clinic. For that amount the building firm could produce a structure of only one and a half stories. Presbyterian's President, Mr. Dean Sage, announced the bad news to a group of doctors associated with the outpatient department, "adding that there would be later additions when the funds were available." Dr. Arthur Neergaard, who was in charge of the medical part of the clinic, "stated flatly that the proposal was a mistake and that it would be better to do nothing at all until there was sufficient money to construct an adequate building" but, in spite the protestations, a committee was appointed to prepare building plans.

In May of 1925, President Sage announced to the Hospital's trustees that the ground plan for the OPD was determined and that the projected building would accommodate the services necessary for Presbyterian and Sloane, although not for the whole Medical Center. More space would eventually be added. Dr. Lamb was harsh in his assessment.

Rarely did Dean Sage stray so far from the facts. He was familiar enough with O.P.D. problems to know that what he was proposing was obviously inadequate even for Presbyterian and Sloane, but apparently he was imbued with the idea of keeping the construction costs within \$600,000.¹³

In his view, the O.P.D. committee spent a great deal of time "in a futile and pathetic attempt to squeeze a clinic to handle 1,200 to 1,500 visits a day and all ward admissions into a truncated structure of one and a half stories."¹⁴ Luckily for the beleaguered planners, excavation was considerably slowed down by the presence of quicksand, a symbolism of which they could likely readily appreciate.

¹³ *Ibid.*, p. 227.

¹⁴ *Ibid.*, pp. 227-228.

In Dr. Lamb's judgement, the Hospital's most significant construction problems came from "an unrealistic attempt to stay within \$7,000,000 allocated." The early estimate was quite off, with the final cost of the Hospital's share of construction approaching \$12 million. "The very conscientiousness with which every economy was pursued came near to causing grave errors."¹⁵ But this assessment was likely only partly true. While there were several other examples where financial pressures led to regrettable decisions, the most conspicuous case of the institutional willingness to cut corners concerned the outpatient service, a hardly random choice.

Throughout early 1926, the OPD planning committee continued the futile effort to plan a clinic of one and a half stories. While concern about the inadequacy of the proposed budget grew, planning proceeded. Frustrated and disappointed with his previous experiences with the main planning committee, Dr. Lamb was nonetheless encouraged to review the OPD process by John Bush. Reluctantly, he agreed to meet with the planning committee.

Immediately they wanted to show me the plans on which they had labored so diligently. I told them that although I was sure the 'plans were excellent considering the limitations of space which had been imposed, I saw no point in going over them. I went ahead to explain that Vanderbilt Clinic just could not be contained in the story and a half with which they had been working. That much space, I pointed out, would just about care for the admitting clinic. It would require an eight- or nine-story building to house the whole program. ... This was all very well, the committee members countered, but could I write out the necessary check? I replied that the cost was not our concern and then plunged into what I considered the proper approach. To be sure, the committee had been told that only \$600,000 was available and that they should plan a clinic of only one and a half stories. They had accepted these instructions literally and had spent much work trying to do what they knew from the outset to be an absurd impossibility. I believed that the responsible Managers really wanted them to state that under the conditions outlined an adequate clinic was impossible and then to offer a plan for a satisfactory one. With that accomplished, the committee's responsibility would end, and the rest would be

¹⁵ *Ibid.*, pp. 237-238.

up to the Managers. The necessary money would then become available, or not. If it did, the committee could proceed with detailed plans. If not, it would be better to do nothing at all than to attempt an abortive plan which would simply stymie the whole vast undertaking. Up until now, whenever the Managers had been convinced that a given course of action was right, they had always followed through. There was no reason to believe that they would break that tradition now.¹⁶

When Dr. Lamb left the meeting, the committee agreed with his position and the quiet revolt against the one-and-a-half-story “abortion” had begun.¹⁷

On the very next day, the Hospital’s chief benefactor, Mr. Edward Harkness, stopped by Dr. Lamb’s office “on a minor professional matter.” Dr. Lamb had always refrained from discussing Hospital problems on such occasions but Mr. Harkness insisted on hearing how things were going. Dr. Lamb told Mr. Harkness of his meeting the day before and asked for his advice. “Don’t budge from that position,” Harkness told the doctor and two days later gave \$250,000 toward the project and practically guaranteed that a sufficient facility would be constructed.¹⁸ At the same time, President Sage began urging Columbia’s President to raise their part of the needed funds. In particular, he was urged to inquire whether the Vanderbilt family – the original donors of the Medical School’s outpatient clinic – would increase their donations. Indeed, soon after Mr. Harkness had made his gift, Frederick W. and Harold S. Vanderbilt contributed \$400,000 for the Clinic’s building and additional \$100,000 for its equipment. Adequate financing was finally assured and the construction plans were completed quite rapidly.¹⁹

In December of 1926, a budget of \$1,366,000 was announced to build and equip a Vanderbilt Clinic of five stories. A month later, three additional floors were

¹⁶ *Ibid.*, pp. 238-239.

¹⁷ *Ibid.*, p. 239.

¹⁸ *Ibid.*, p. 239.

¹⁹ *Ibid.*, pp.239-240.

added to the plan in order to include the Dental School in the building. “At last,” wrote Dr. Lamb, “we had our eight-story Vanderbilt Clinic.” Although it would have been appropriate to include an outpatient dental department, he thought that the whole Dental School should not have been lumped together with the Medical Center’s outpatient clinic. While not perfect, he thought Vanderbilt Clinic was well conceived and has served its purpose well for more than twenty-five years. On the whole, it was “surely worth the fight we made for it.”²⁰

The entire episode surrounding the construction of the Medical Center’s outpatient department revealed several features of intra-organizational politics. While the value of outpatient department as a feeding pipe of inpatients was apparent to all professional and administrative leaders, a more specific interest in adequate facilities and decent working environment was limited to those closely associated with the work of the outpatient clinic. The advocacy for an adequate outpatient service then fell upon the shoulders of those younger or less successful physicians assigned to the outpatient work. Close association with the clinic in the past also facilitated increased interest in adequate provision for the outpatient facility at the new Medical Center.

The Problem of the Semi-Private Patient

Beginning in 1922, planning for hospital ward construction proceeded swiftly. The layouts of different floors and services were determined in conferences between the architect and building firms and professional and administrative staffs of the departments involved. The process worked so well that the planning of the ward floors was completed by the end of 1923.²¹

But a different set of problems with the planning process had soon emerged. Guided by the idea of full-time appointments in all departments, initial plans did not

²⁰ *Ibid.*, p. 240.

²¹ *Ibid.*, p. 186.

include accommodations for private patients. When the strict full-time idea was defeated, the frustration felt by the doctors with the insufficient number of private rooms at the old hospital has been brought out into the open. Moved by the hints from some of the professional staff as well as his own foresight, in 1924 Edward Harkness persuaded his mother to make a gift of a private patient building in memory of her husband. Named Harkness Pavilion, the structure was entirely separate from the wards, providing 150 rooms for accommodating private patients, their guests, servants, or special nurses.²²

Although the gift was received with both gratitude and relief, the resulting building left much to be desired. Harkness Pavilion was “too narrow” and “not well planned.” Worse yet, “[e]ach floor was arranged to include both expensive rooms with bath and the less expensive ones without. Consequently, there could be no differentiation of services by floors.” The building’s elevators were markedly inadequate and no soundproofing was planned. Both problems had to be confronted after completion and in a decidedly regrettable manner.²³

The issue of private room service remained controversial for at least another decade. As late as 1932, President Sage argued that New York was “suffering from the oversupply of private beds” and that even upon recovery from the economic depression hospitals would not recover the former level of earnings from private patient services. Two years later, however, he had changed his position, declaring in his annual report that “more and more, the Hospital must look to operating income for support. This means a building up of private patient occupancy since this is the only service in which our income is greater than our out-go.”²⁴ In 1936 Harkness Pavilion

²² *Ibid.*, p. 187.

²³ *Ibid.*, p. 187.

²⁴ *Ibid.*, p. 308.

was enlarged with adding three more floors, even if over objections of many older trustees. In addition, a three story building adjoining the Pavilion was built to provide facilities for X-Ray, therapy, and allied services. The project met with considerable resistance from many trustees who argued that anticipated occupancy would not make enlarged service profitable. No sooner than the improvements were completed than it became obvious that demand for private service would far outstrip supply.²⁵

Although it was felt that the Harkness Pavilion was poorly designed, on the whole the new Medical Center provided excellent accommodations for both ward and private room patients. The problem was – as in so many other hospitals during that time – accommodating the so-called semi-private patients, people of moderate means who could not afford private room rates but would not enter charity wards. In the new facilities at the Medical Center, just as in the old Hospital, no provision was made for this category of patients. The Great Depression, which struck the country soon after the Center opened, threw the need for moderately priced service in sharp relief as many rooms in Harkness Pavilion stood empty. In an attempt to provide some kind of a solution, the smaller and more moderately appointed rooms were made available at lower rates. Additionally, in 1928 rooms adjacent to the wards in the main hospital building – originally designated for “the dying, infectious, noisy and disfigured patients” – were converted into the semi-private rooms. This, of course, was a temporary and unsatisfactory solution yet it took another ten years before the Committee to study the semi-private situation was appointed.²⁶

²⁵ *Ibid.*, pp. 308-310.

²⁶ The Committee appointed to study the semi-private question found a useful model in the solution found at the Massachusetts General Hospital in Boston. Upon taking a personal visit, the Committee based many of its recommendations on the successful operation of the Baker Memorial Unit, a 300-bed semi-private facility of MGH. In addition, the semi-private unit, which the Mount Sinai Hospital of New York was compelled to open a short while ago, was also studied.

The findings and recommendations of the study were summarized in the “Report on the Semi-Private Situation at the Presbyterian Hospital,” dated June 2, 1937.²⁷ The Report stated that, under current arrangements, Presbyterian was mixing semi-private patients with ward patients on the one hand, and with private patients on the other, and argued that these three different categories of patients should not be so mixed.

There was no longer any doubt that there existed a great demand for semi-private accommodations and the hospital as large as Presbyterian, argued the authors of the Report, owed it to the community to furnish hospital care at reasonable rates. Such service was urgently needed for yet another reason. While the majority of doctors on the staff at Presbyterian had among their clients those who fit the definition of ‘semi-private’ patients, the greatest need for moderately priced accommodations was among the younger doctors on the staff. Many senior physicians built up successful practices by serving patients of moderate means and, if Presbyterian was to keep its younger doctors, it had to provide adequate semi-private service.

The number of make-shift semi-private rooms – 82 in all – did not convey the frustrations faced by the doctors and patients alike.

The inability to tell a patient when a room will be available, the constant telephoning to the hospital and to the patient, the awkwardness of having to send sick out-of-town patients home to wait until there is space, the necessity of sending patients to other hospitals because the Medical Center has no room, make up a set of circumstances which are both discouraging and irritating – more especially to the younger men who are trying to establish a practice. The Hospital loses friends inevitably as a result of this situation.²⁸

²⁷ “Report on the Semi-Private Situation at the Presbyterian Hospital,” June 2, 1937, reprinted in Albert R. Lamb, *The Presbyterian Hospital and the Columbia-Presbyterian Medical Center, 1868-1943* (New York: Columbia University Press, 1955), pp. 459-466.

²⁸ *Ibid.*

As a result there was a long waiting list for semi-private patients who wished to enter Presbyterian for non-urgent procedures. In this regard the Report wryly noted that whereas the waiting list “has been considered an attractive feature in making clubs exclusive ... it is not an asset to the doctor who is trying to take care of patients who need hospitalization.” It should not be forgotten, warned the authors, that “well satisfied semi-private patients of today ... often become the private patients of tomorrow.”²⁹ The questionnaire sent to all doctors on the staff at Presbyterian revealed that in 1936 the doctors had to send at least 234 semi-private patients to other hospitals in the city. This not only placed heavy demands on the doctors’ time, having to care for the patients hospitalized in different parts of the city but caused considerable irritation to patients and their friends.

The Report emphasized that the make-shift semi-private accommodations in the main hospital building decreased the already inadequate number of ward patients needed by the affected serviced to fulfill their teaching duties. Mixing private and semi-private patients in the Harkness Pavilion was even worse. “There are too many common facilities-entrance, admitting, elevators, roof, reception rooms, solaria, bathrooms, etc., and the floors are so arranged that unless you use the larger rooms with baths at a [semi-private] rate, you have private and semi-private patients on the same floors.” This situation nearly invited abuse, the Committee wrote. “It did not take people long to get onto the fact that a room for which they were paying \$10.00 to \$15.00 on the 8th Floor could be duplicated for \$7.00, with the laboratory discount, a floor or more down.” The answer, argued the Committee member, was obvious: “[e]ach type of service should have a separate and largely self-contained unit.”³⁰

²⁹ *Ibid.*

³⁰ *Ibid.*

The Committee's recommendations were largely based on a careful study of the Baker Memorial Unit, a semi-private facility of the Massachusetts General Hospital in Boston. The study reported that Baker was to a great extent a self-contained eleven-story unit, with its own operating and delivery rooms and X-ray department. It shared with Phillips [the Hospital's private patient unit] the clinical pathological laboratory and the kitchen. The menu was limited in Baker, and the best food was sent to Phillips. In Baker, for a bed in a nine-bed room the daily charge was \$3.70, for a four-bed room, \$4.50; for one in a two-bed room, \$5.50; and for a single room the rate was \$6.50. The Committee learned that the nine-bed wards had been installed to care for "compensation" cases, but had turned out to be a source of constant trouble. The two-bed wards had little demand, but the four-bed wards were well occupied. Most successful were the 157 single rooms.³¹

Baker collected professional fees, with the maximum professional fee set at \$150 for a hospital stay of three months or less. For a longer stay, an additional fee might be charged, but no more than \$150 in an additional three months. A deposit was required from each patient at the time of admission. As money was collected, it was applied to hospital charges and then, what remained, to the professional fees. Each patient was carefully checked to ascertain whether he belonged in the semi-private or in the private service. Operating on this basis, Baker succeeded in collecting over 98 percent of the hospital charges.³²

The Presbyterian's observers concluded that, although not perfect, Baker offered valuable example. The Committee concluded that the best plan for Presbyterian would be to build a unit containing only single rooms. They found those in Boston too small and lacking in proper facilities. Each was furnished with an open

³¹ Lamb, pp. 325-326.

³² *Ibid.*, p. 326.

basin but no toilet, and the closet space was inadequate. The Committee concluded that a good semi-private room should have a toilet and wash basin at one side of the door and an adequate closet at the other.³³

Presbyterian's Committee found the cap on professional fees imposed at Massachusetts General to be questionable and the arrangement whereby the hospital collected professional fees was sure to raise objections from the medical profession. The latter, however, might have to be replicated at Presbyterian, they concluded, because with the low-income patients the doctors often had particular difficulty.³⁴ The problem, in Dr. Lamb's words, was that many among the semi-private group were "poor but proud." Unwilling to go to the wards, they entered the semi-private service even though the charges overtaxed their budget. When they settled their hospital bill, there was often little or nothing left for the doctor. Therefore, if it could be arranged for the hospital to collect both fees from semi-private patients, it might prove very helpful.³⁵

The ideal organization of patient service, recommended in the Report, had to proceed from clear realization that the Hospital served three distinct groups of patients and had different interest in regard to each. The first group consisted of ward patients who were either treated for free or paid what they could up at the time paid from nothing to \$4.00 a day. The Report stated that ward patients "represent a community and teaching obligation. The hospital loses money on this group, as it should." The semi-private patients were paying \$6.00 per day which was more or less a proper rate. Whatever rate may be set at the separate semi-private facility, it should assure that the Hospital did not incur losses from semi-private care. "The plan should guarantee the

³³ *Ibid.*, p. 326.

³⁴ *Ibid.*, pp. 325-327.

³⁵ *Ibid.*, p. 327.

hospital a little better than an even break.” A reasonable range for private service at Harkness Pavilion would be from \$8.00 to \$25.00, or even more than that, per day. Private patients, noted the Report, were “the only patients from whose care the hospital is entitled to, and receives, a profit.” With this in mind, it recommended that “the profits should be fair, without nuisance charges, and the service, from entrance to discharge, should be above criticism.”³⁶

Taking their cue from the Massachusetts General, the authors of the Report wanted to do away with such terms as “private,” “semi-private,” “group private,” and “white-collar” because they suggested invidious comparisons. In Boston, these terms were no longer used and one spoke of “Phillips House patients” [the private unit], “Baker patients,” or “pavilion [that is, ward] patients.”³⁷

Alas, the semi-private unit for the Medical Center was not realized in the years before the start of the war. Part of the reason may have been that President Sage continued to believe that it was very possible that the semi-private service would compete with Harkness Pavilion to the detriment of the Hospital’s income, even though the study showed otherwise. More likely, however, the project never got off the ground because instead of trying to raise estimated \$3 million dollars, the estimated cost of a 300-bed semi-private unit, President Sage was asking another \$5 million for an entirely different purpose. Dr. Lamb, who was among the authors of the study, believed that had the extra \$5 million were not tacked onto the price tag of the semi-private facility, Edward Harkness would have financed it.³⁸

In 1941, however, the administration did make some improvements in the designation of rooms in Harkness Pavilion, approximating something like a

³⁶ “Report on the Semi-Private Situation.”

³⁷ Lamb, p. 325.

³⁸ *Ibid.*, p. 332.

differential service by floors. Previously the sixty group private rooms had been dispersed throughout several floors together with higher priced rooms, an arrangement which was strongly criticized. Now floors 3, 4, 5, and 6 were converted into a kind of low-income service. Fifty-nine rooms, the less desirable ones on the four floors, were to be let at \$7 per day and given a less elaborate service, which resulted in a considerable economy for the Hospital. Seventeen other rooms on these floors were to be used for personnel and six for endowed beds. These were more desirable rooms, most of them with baths. The rates on floors 7, 8, 11, and 12 were revised to provide a greater number of moderately priced rooms. No patient paying \$7 a day was to be housed above Floor 6 for less than the established rates except when an emergency arose or the number of personnel exceeded the quota. In view of the faulty planning of the Pavilion, this was a reasonable makeshift in the direction of segregating different types of service on different horizontal levels, by all odds the most sensible way to provide a proper number of low-cost and medium-cost rooms.³⁹

The failure to devise a comprehensive solution to the semi-private patient problem was not atypical. During this period, it was not uncommon for hospitals to approach the question of semi-private patient with apprehension. The Report of the Committee to study the semi-private situation captured the generalized feeling among doctors and hospitals about providing service to low-income patients: “[o]ne has only to experience the difficulty of trying to care for people with limited means to realize how much the doctor has to give of himself and of his time to accomplish the desired result.” Some of the problems were stated in the Report but, generally, the margin of profit that could be earned on semi-private care was very small and, if every aspect of the service was not carefully thought out, it could easily incur deficits. Another

³⁹ *Ibid.*, pp. 379-379.

complicating factor was the negative experience which many hospitals, including Presbyterian, had with the emerging hospital insurance plans.

In the spring of 1935, President Sage presented to the Managers a proposal to join the Associated Hospital Service of New York, a hospital insurance plan sponsored by the United Hospital Fund. The plan outlined the list of services that the Hospital would furnish to covered patients at a rate of \$6 a day. The Managers authorized the President to file the application to join the plan, subject to a further consultation with the professional staff. Upon reviewing the proposal, the Medical Board voted against it, arguing that given the Hospital's present semi-private facilities, the patients admitted under the plan would take up the rooms in Harkness Pavilion but would pay no laboratory and other fees that would be normally charged to the semi-private patients staying at Harkness. Conversely, many patients who would ordinarily go into the wards would take semi-private rooms, receiving more than the usual semi-private patient and would not expect to pay a doctor's fee.⁴⁰

President Sage, however, did not agree with the Board and decided to proceed with the application unless the Managers objected. Although he noted the Board's position, he felt that the Hospital should join the plan "as a matter of public policy and service." Professional staff naturally resented the President's decision believing that the Hospital and the doctors should not accept a plan that would entail financial losses. Some of the problems with the plan were addressed at a later time but the main problem, in the opinion of the professional staff, remained: "furnishing many services to semi-private – and soon to private patients as well – without any corresponding remuneration to the Hospital." It was estimated that under the plan the Hospital lost about \$150,000 annually. While the growth of hospital insurance was recognized as a

⁴⁰ *Ibid.*, pp. 340-341.

permanent phenomenon, many felt it was wrong to subsidize hospitalization of the lower middle class from the funds of the charitable hospital.⁴¹

It was widely felt at this time that insurance plans were appropriate only for the lower middle-income group. The fear was that the increasing number of patients, presumed able to afford private rates, were enrolled in these plans. Financial strategy that the voluntary hospitals developed for the past several decades, aimed to charge patients in accordance with their economic status was now under threat. If the insurance plans continued to spread into the higher income groups, they threatened to equalize the revenue which hospital received from caring for patients from different economic groups, effectively eliminating the large part of the profits derived from the differentiated fee scales in the semi-private and private service.

Hospitals were reluctant to sign onto these insurance plans and, if they did, attempted to provide the 'compensation' patients, as they were called, with the level of service just above that of the wards. Usually, they were accommodated in the oxymoronically titled 'private wards,' or in 'group private' service. These were, essentially, small wards which, presumably, accorded the lower middle-class patients if not privacy, than some assurance of not being mixed with the denizens of the ward. At Presbyterian, some patients who were admitted to semi-private rooms under the Associated Hospital Service insurance plan were transferred to the wards because of their inability to pay the doctor's fee. The Hospital decided that any profit arising from such transfers would be allocated to the educational and research funds of the department rendering the care.⁴²

In 1941, Dr. Sigmund Goldwater, New York City's Commissioner of Hospitals, and the Associated Hospital Service proposed a new plan which would

⁴¹ *Ibid.*, pp. 340-342.

⁴² *Ibid.*, p. 342.

essentially insure low-salaried patients for the cost of ward care and associated physicians' charges. A memo outlining the proposed plan, to be known as Community Medical Care, was distributed to the members of the Center's Medical Board in May. No immediate action was required, but in its discussion the Board agreed that insurance plans should involve compensation for the insured by the insurance company and that Hospital should be careful to make no commitments that would entail financial losses. The Board felt that the original Associated Hospital Service plan did involve a loss to the Hospital and should stand as a warning. Also, physicians' fees for ward patients were entirely foreign to the Hospital's traditional policy and should be approached carefully. Finally, Presbyterian was a teaching hospital and it would be "a serious error to enter an arrangement which might curtail the free choice of cases needed for teaching purposes."⁴³ Three members of the Board were appointed to write a full report on the proposed plan and their document emphasized the following points.

Adoption of the plan might well result in interfering with the number and variety of cases to be used for teaching. The American Medical Association's approval of the Hospital for training interns might be jeopardized. Work for the nursing staff would become more complicated, and there might be confusion among the attending physicians, the residents, and the interns as to who should be paid. From the proposed contract, it was not clear how many extra services would be provided. On the other hand, if Presbyterian did not adopt the plan, patients who could pay the full rates might go to hospitals which had adopted the plan. The professional fees from a patient insured under this plan might be pooled for distribution among the various doctors who had contributed to the case. The problems of the costs of medical care to the layman and the threat of socialized medicine should be kept in mind.⁴⁴

Later that year, Presbyterian's Medical Board met with Dr. Goldwater to discuss the plan. Although he argued strenuously against every objection, the members

⁴³ *Ibid.*, p. 381.

⁴⁴ *Ibid.*, p. 381.

of the Medical Board were not wholly convinced. After a stir of opposition from other corners of the City's medical profession, Presbyterian's Medical Board declared itself against the plan, calling it "neither sound nor in the public interest" and "not in accord with the teaching functions of the Hospital." Discussions of the project dragged for another two years, which the Medical Board again reiterated its stand of being unequivocally opposed to the Hospital's "underwriting" of this or any other hospitalization plan.⁴⁵ Not until some time after the war, did the Center come to the realization that "a substantial portion of the population will have some form of prepayment medical care insurance, including a large fraction of the patients admitted into the wards of the hospital at the Medical Center."⁴⁶

Institutional Purpose and Structure: Rhetoric and Reality

The conflicts surrounding the construction and expansion of the Medical Center revealed some of the most underserved patient groups – the lower class ambulatory patients and the lower-middle class inpatients. Intimately connected with their plight was relative powerlessness of those segments of the medical profession most likely to serve them, namely, the younger, less successful physicians in general medicine and related fields. The completed Medical Center and directions of its early growth revealed a far more complex structure of division and subordination which eluded even the most pragmatic statements of institutional purpose.

Presbyterian Hospital's Annual Report of 1926 was symptomatic of the mismatch between stated institutional objectives and the actual organizational hierarchy. Written by the Hospital's President, Mr. Dean Sage, the report looked

⁴⁵ *Ibid.*, p. 382.

⁴⁶ Willard C. Rappleye, *The Current Era of the Faculty of Medicine, Columbia University, 1910-1958* (New York: Columbia University Press, 1958), p. 58.

toward the completion of the Medical Center from a broad perspective of its institutional mission.

A teaching hospital is an outstanding unit in community life. Its activities are not confined within its walls. They touch the mainsprings of the social organization. The layman is apt to conceive the Hospital's function in relation only to its bed patients. That is truly a most important work but, properly evaluated, by no means its only great contribution. We must look to preventive medicine in the broadest sense of that term, for a test of the ultimate social value of the Hospital.⁴⁷

The opening statement was followed by a discussion of the various parts and services of the Medical Center which furthered its central institutional goal. Both the content and the order of discussion are notable. The pride of place in furthering the cause of preventing disease was given to the outpatient clinic.

The Out-Patient Department or Clinic yields the most patent example of hospital activities directed toward preserving the economic status of the individual. This type of preventive medicine is growing enormously in importance. Its endeavor is to keep the patient out of a hospital bed except where the ultimate diagnosis discloses the real necessity of such treatment. Obviously, if the sufferer can be restored to health while still an ambulatory case, he is best served and so is the community, for the economic waste of a complete removal from social usefulness has been avoided.⁴⁸

The functional thrust of this conception, with its heavy emphasis on work ethic prescription for the working classes, is unmistakable. But even a sympathetic account could find faults with it. While praising President's report as a "well-written essay [that] affords a picture of the whole," the Hospital's historian concluded that, under the circumstances of the time, the great emphasis laid placed on avoiding hospitalization was actually mistaken. "It required so many appointments for consultations and laboratory examinations that the net expense and loss of time were

⁴⁷ Presbyterian Hospital Annual Report 1926.

⁴⁸ *Ibid.*, p. 242.

greater than for a couple of days spent in the Hospital, where a comprehensive work-up could be quickly accomplished.” As things were, however, the clinic patients had to take half or an entire day off from work or household responsibilities to hold each appointment. Not until much later could appointment and diagnostic time be significantly shortened.⁴⁹

The second division of the Medical Center which President Sage chose to highlight was the Social Service Department.

The Social Service Department is another important adjunct to preventive medicine as well as a necessary link in the care of patients within the walls. Through this department, contact is maintained between professional treatment at the Hospital and the environment of the patient as a member of the social body. It advises the doctor in charge of background and environmental conditions which directly bear upon the condition of the patient and indirectly upon the treatment to be accorded him. Furthermore, it is the province of Social Service to see that the patient is relieved as far as possible from the anxieties attendant upon a family whose welfare is unprovided for while its head is in confinement. This is done by establishing contacts with other organizations which are devoted to social aid and in some cases by the actual application of such aid.⁵⁰

Next in the discussion came nursing. Presbyterian had always considered its Nursing School to be among its greatest contributions to community service. The nurses, “through their administration to the sick, and particularly in public health nursing and teaching, contribute directly to the prevention of disease.” The question of the degree and kind of training in the sciences to be given to nurses was moot, claimed the President, but it was “safe to say that the proper tendency should be toward equipping the graduate to undertake any field of work which may interest her, whether it be hospital nursing, private nursing, public health nursing, or education.”⁵¹

⁴⁹ Lamb, pp. 242-243.

⁵⁰ Annual Report 1926.

⁵¹ *Ibid.*

The operation of the Department of Nutrition was described next, as affording “an opportunity of bringing to the home much medical instruction in the art of preserving health through a proper understanding of the meaning of diet.”⁵² In point of fact, the newly-built Medical Center instituted an important structural innovation, removing meal service, as well as preparation of menus and food, from the province of the nurses to that of the Department of Nutrition largely independent from the nursing service.⁵³ From nutrition, the Report moved on to the Department of Occupation Therapy which “deals with the problems of inactivity resulting from hospital confinement” and the planned building of the convalescent home which had to be postponed due to the heavy financial demands of current construction. Finally, the Report turned to the functions of teaching and research.

Doubtless the greatest contribution to preventive medicine made by a teaching hospital is found in the furnishing of clinical and laboratory facilities to the professional staff. Medical practice, research and education are hand-maidens in a common task, the securing of the public health-no one of them can succeed without the assistance of the others. Together they seek not only the alleviation but also the prevention of human suffering. To their common effort, resulting in the application of an aggregate of brains to a given problem, the world must look for the great medical discoveries of the future which may make the world a safer and better place in which to live.⁵⁴

In view of the actual relegation of the outpatient department to the last line on the budget, it is easy to see that the President’s report placed first what was in fact the most dispensable and the least funded enterprise. Distinctly feminized and de-classed fields of nursing, nutrition, social work, and rehabilitation were largely service-centered functions or, at best, professionally marginal areas. In point of fact, Report’s

⁵² *Ibid.*

⁵³ Lamb, pp. 245-246.

⁵⁴ Annual Report 1926.

order of discussion was nearly the reverse of the actual order of institutional privilege and functional importance.

Even if the enthusiasm for preventive medicine and community service was real among administrators and philanthropists, the actual architecture of the Center's activities did not bear it out. Many public health and community service functions were abandoned or limited with the move to the newly Medical Center. During the years of preparation for the move to the Medical Center, several services were discontinued. In 1925 Presbyterian transferred general visiting nursing for its district, together with the training of nurses in public health nursing, to the Henry Street Visiting Nurse Service. The Hospital's social service department had gradually discontinued its commitment to help patients financially, except when such aid was necessary to obtain things prescribed by doctors for medical treatment. This change was apparently made to avoid duplication of services offered by other agencies in the community. Both inpatient and outpatient departments discontinued programs for treatment and prevention of tuberculosis, ostensibly because this responsibility was assumed by New York City's departments of Health, Hospitals, and Public Welfare.⁵⁵

There were also significant changes in social service. In anticipation of the move to the Medical Center, a plan for a single department of social service was drawn up. It proposed to separate social work from the public health nursing and more strictly subordinate it to the clinical medicine. The Vanderbilt Clinic Auxiliary, a committee of interested women who was largely responsible for organizing and funding the social work at the old clinic, was removed from direct management but continued the general sponsorship of the unified department.⁵⁶ The plan envisioned

⁵⁵ Lamb, p. 278.

⁵⁶ However, the chairman of the former Vanderbilt Clinic Auxiliary, Mrs. Yale Kneeland, was made a member of the Presbyterian Board of Managers and of the Board's Social Service Committee. [Lamb, p. 276.]

that the Director of the new department was to be approved by the Medical Board and the Board of Managers. The teams of social workers, selected by the director and approved by the administration, were to be attached to each major clinical division. Many of the social workers, who had previously combined nursing and social work, “obligingly adapted themselves to the new division of labor among nurses, social workers, dietitians, and clinic aides.”⁵⁷ Increased specialization and the narrowing of the field’s focus were notable in the work of the reorganized social service department.⁵⁸

More than any other, the discontinuation of the Katie Geitz’s Kitchen seemed to mark the end of an era. For many years, the Kitchen was one of the auxiliary services which helped create good will for the Presbyterian Hospital. This is how Dr. Lamb described this institution.

In 1904, Katie Geitz, a frail German-born woman, was admitted to the Hospital. She remained as a ward patient for a year. Although her life was saved, she was to retain a permanent limp. Meanwhile, the Visiting Nurse Department, generously helped by Mrs. William K. Vanderbilt, was being organized. An important part of the program was the establishment of a milk kitchen in Yorkville to fight malnutrition in tubercular and other undernourished children. In charge was Katie Geitz, who was grateful to Presbyterian for her recovery and who had endeared herself already to the Hospital personnel. She carried on for some twenty years. At first she distributed only milk, but soon also fed Yorkville children the fresh eggs

⁵⁷ Lamb, pp. 278-279.

⁵⁸ In 1925, for example, at the suggestion of Dr. Auchincloss of the Surgical Service, the social work department began the study of medical-social terminology for classifying and indexing social maladjustments. But the closer association between social work and medicine may have been a double-edged sword as well. In 1930, for instance, a female doctor was appointed to supervise a comprehensive study of the relation of social disorders to medicine, undertaken under the auspices of the Social Service Department. The study’s conclusions were that “[s]ocial disorders were present in about half the cases” of physical illness studied and in some of these, “the social disorders clearly accounted for much of the disability since the patients, though long damaged by the disease, had not been disabled until some disturbing change occurred such as failure in business.” The study was made possible by the grant of \$10,000 from the Auxiliary and the report was published as *The Social Component in Medical Care*. [This account of social service is drawn from Lamb, pp. 275-280, whose own account was based on the work of Miss Janet Thornton, head of the Social Service Department at CPMC from 1924 to 1947.]

brought in from Vanderbilt farms. During the depression of 1907 she distributed bread. In later years she prepared school lunches for the children. When she retired on March 26, 1925, the Hospital gave a reception for her at Nightingale Hall and many grateful persons came to tell her good-bye. The Managers voted her a gift of \$250.⁵⁹

Proceeding at an accelerated pace during the period of transition, addition of some and discontinuation of other services revealed two partially intertwined logics shaping American medicine – the hierarchical structure of medical specialties and the division of labor between private and public providers of care.

Although a prominent general hospital, Presbyterian could not by itself offer adequate teaching facilities across the entire range of clinical specialties. Facilities for instruction in obstetrics and gynecology were secured through merger of Sloane Hospital for Women with Presbyterian in 1925.⁶⁰ Teaching and research in pediatric medicine was made possible by affiliation with Babies Hospital, which agreed to move to the Medical Center in the same year.⁶¹ Another hospital to affiliate with the Medical Center at the time was the Neurological Institute.⁶² The need to expand the Center's facilities in orthopedics was felt early on and formal negotiations with the New York Orthopaedic Dispensary and Clinic began in 1941. The war has postponed the process but the official affiliation was secured in 1945 and the Orthopaedic Hospital moved to the Center in 1950.⁶³ In an effort to broaden its involvement in the problems of rehabilitation and physical medicine, the University affiliated with the Institute for the Crippled and Disabled in 1947.⁶⁴

Other notable structural changes included considerable expansion of urological and ophthalmological services. In 1924, Director of Urology, Dr. J. Bentley Squire,

⁵⁹ Lamb, pp. 253-254.

⁶⁰ *Ibid.*, p. 225.

⁶¹ *Ibid.*, p. 228.

⁶² *Ibid.*, p. 232.

⁶³ *Ibid.*, p. 357.

⁶⁴ Rappleye, p. 61.

offered to finance the construction of one whole floor to be devoted to his specialty and to raise an endowment fund to cover its operating deficits. Floor 10 of the new Presbyterian Hospital building was accordingly designated for the Squire Urological Clinic.⁶⁵ In 1931 Edward Harkness offered \$5 million to endow an Institute of Ophthalmology at the Center.⁶⁶ In 1940, the Hermann Knapp Memorial Eye Institute, one of the pioneer institutions in the field, merged with Columbia-Presbyterian's Institute of Ophthalmology, transferring most of its funds, patients, and staff.⁶⁷

All of these additions and affiliations concerned private institutions and donations and they revealed to some extent the working out of several principles in American hospital system. The expansion of Presbyterian's urology department into an independently funded Squire Urological Clinic and the endowment of the Institute of Ophthalmology exemplified the power of male-dominated surgical specialties. Conversely, the absorption of the Sloane Hospital for Women and the Babies Hospital typified the disappearance of the institutions established through women's philanthropy and activism in the second half of the 19th century.⁶⁸ The affiliation with hospitals specializing in orthopedics and rehabilitation underscored the secondary status of these specialties which until after WWII served mostly low class clienteles.

If the pattern of institutional affiliations with private hospitals revealed relative prestige and power of medical specialties and their clients, relationships which the new Medical Center established with public entities bespoke an even starker division

⁶⁵ Lamb, pp. 186-187, 241.

⁶⁶ *Ibid.*, pp. 292-296.

⁶⁷ *Ibid.*, pp. 354-355.

⁶⁸ The central role of Emily Vanderbilt in the establishment of Sloane is discussed in Chapter 4. Babies Hospital was founded in 1887 by Mrs. Andrew H. Smith, Mrs. Thomas E. Satterthwaite, Mrs. James Lenox Banks, Dr. Sara J. McNutt, and Dr. Julia G. McNutt. [This information is from Lamb, p. 228, which was in turn drawn freely on an article written for Dr. Lamb by Miss Winifred Kaltenbach, Superintendent of Babies Hospital from 1929 to 1946.] The end of Katie Geitz' Kitchen and reorganization of the Social Service from control by the Women's Auxiliary were the other parts of this process at the Medical Center.

of labor. The establishment at the Center of a solid base for work in psychiatry and oncology, for example, was made possible through bringing into the geographical union of the two public institutions – the New York State Psychiatric Institute and the city-owned Francis Delafield Hospital for the treatment of cancer. The Psychiatric Institute and Hospital was built at the Center concurrently with all of its major original buildings. The decision to locate a cancer hospital at the Medical Center was reached many years later. Both, however, were part of the larger relationship of the private Medical Center and the various parts of the public health care system.

According to the account published by the Dean of Columbia's Medical School, in 1935 the New York City Commissioner of Hospitals, Dr. Sigmund S. Goldwater, created the Research Council in Chronic Diseases and approached the University for aid in implementing the highly desirable program. As the plans to establish a city-owned hospital for chronic diseases took shape, Columbia entered into negotiations with the city to affiliate with the future institution. The Hospital for Chronic Diseases, later named the Goldwater Memorial Hospital, was built on Welfare Island. The plan called for a unit for research and teaching and Columbia's Medical School was placed in charge of one of the divisions of this unit.⁶⁹

In 1936, the University began talks with the City about a similar role in the staffing of the cancer hospital planned by the City. Initially, the City intended to build this hospital on Welfare Island, too, but Columbia persuaded the city that the acute professional care required by cancer patients would be hard to provide on the Island because of transportation and other difficulties. Edward Harkness' purchase of the block of land just south of the Medical Center in 1937 enabled the University to bring the future Francis Delafield Hospital in close proximity with Columbia-Presbyterian.⁷⁰

⁶⁹ Rappleye, pp. 30, 31-33.

⁷⁰ *Ibid.*, p. 32; Lamb, pp. 333, 355-357.

The College of Physicians and Surgeons also staffed and used for the instruction of students Bellevue Hospital's Tuberculosis Service. In 1938 the Service moved into a new pavilion of 270 medical and 47 surgical beds. According to Dr. Lamb, "[t]he thoroughly modern unit included an excellent teaching amphitheater, laboratories for the investigation of respiratory and cardio-circulatory function, a library, special units for collapse therapy, chemical and bacteriological laboratories, and operating rooms."⁷¹ In his annual report, the Dean of the College predicted that the service would be of even greater importance to the Medical School in the future.

In 1939, a new 50-bed service for diseases of the skin opened in the Welfare Island Hospital for Chronic Diseases was made available for training of Columbia's medical students. In Dr. Lamb's words, this relationship helped "compensate for the inadequate facilities of the Dermatological Service at Presbyterian."⁷²

Another visible project of cooperation with the public health institutions was the establishment of the Washington Heights Health and Teaching Center. In 1934 the Dean of the Medical School began negotiating with the City of New York in regard to locating one of the City's new health centers at Columbia-Presbyterian. The Center would provide training opportunities for members of the Department of Health, the Visiting Nurse Service, Family Relief and Social Service Agencies through the

⁷¹ Lamb, p. 382.

⁷² *Ibid.*, p. 382. Especially after WWII, Columbia-Presbyterian and its top officials were also involved in various city and state health care initiatives. In 1945, at the request of the Veterans Administration, Columbia's medical faculty joined with other medical schools of the city to create a joint deans' committee to organize and direct the teaching and resident staff of the Veterans (Kingsbridge) Hospital. The committee's role was soon extended to include the nomination of the full-time professional staff and consultants. Dean Rappleye of Columbia's Medical School was the first chairman of the New York Deans' Committee. The University staff took an active part in the development of the Health Maintenance Demonstration at Montefiore Hospital, initiated by the Community Service Society of New York working in collaboration with the Health Insurance Plan of Greater New York. In the early 1950s Dean Rappleye became one of the original members of the newly created Board of Hospitals for the city of New York which was to "serve as the top policy-making body of the Department of Hospitals" responsible for "developing long-term programs for the care of the aged, sick, and infirm of the city and to permit the highest possible standards of medical care in the municipal institutions. [Rappleye, pp. 54, 68-69.]

creation of appropriate courses adapted to the needs of variety of such personnel. It would also afford experience in public health nursing to students in the School of Nursing and assume some of the public health activities of the Vanderbilt Clinic, the Center's outpatient department. The final agreement was reached in September of 1936 and the center, situated at the corner of 168th Street and Broadway, opened in 1940.⁷³ In 1945, Columbia organized a course in hospital administration at the Center and the program became one of the leading educational efforts in this field in the country. Five years later the Institute of Administrative Medicine was created as an outgrowth of the program and was renamed the School of Public Health and Administrative Medicine in 1955.⁷⁴

Even a cursory overview of the Center's relations with a number of public health care institutions and initiatives suggests that they conformed to the traditional division of labor between private and public institutions established as early as the 18th century. It will be recalled that the first American voluntary hospitals were established not to share in the public burden of caring for all sorts of social and physical ills, but to save from the indignities of the public almshouse only those who were morally deserving. In practice, however, not only the victims of their own licentiousness, but many other merely troublesome and disturbing categories of patients were turned away. Voluntary hospitals routinely rejected not only the

⁷³ Lamb, pp. 314-315; Rappleye, p. 31.

⁷⁴ Rappleye, pp. 35-36. The account of the relationship between the CPMC and the public health care institutions would be incomplete without the mention of the compensation that Presbyterian was receiving from the City for the so-called City cases. Dr. Lamb's history, for instance, reports that, in the course of investigating its financial situation in 1940, Presbyterian had found that its "income from City cases was considerably lower than that of New York and Mt. Sinai hospitals. In 1938, for example, New York Hospital had received some \$138,000 while Presbyterian got some \$63,000. Since the two institutions were nearly the same in size, the loss taken by Presbyterian resolved itself mainly into a matter of not using proper terminology in reporting cases, particularly emergencies. This was brought to the attention of the Medical Board, and appropriate steps were taken." Direct compensation was, of course, in addition to the tax-exempt status and other public subsidies to the various institutional parts of the Medical Center. [Lamb, p. 377.]

syphilitic and the alcoholic, but also those suffering from tuberculosis, any and all contagious diseases, mental disturbances, cancer and other incurable maladies, as well as the chronically ill and the aged. Moral or not, with few exceptions, voluntary hospitals transferred such patients to the city institutions.

Even after most of the old almshouses evolved into public hospitals, their patients – as well as their staffs and services – differed markedly from those at the private institutions. Thus, the voluntary and public hospitals existed in a complementary relationship and the rapid growth of the private institutions did not reduce the need for the public ones, quite the contrary. Well into the twentieth century there was a clear division of labor among the two: the private hospitals creamed the population of social and medical ailments, taking in the more profitable and professionally rewarding cases, while the public institutions were left to take care of the rest.⁷⁵

It is not surprising, then, that the psychiatric or cancer hospitals at CPMC were publicly owned or that Columbia was happy to staff and instruct its students at public hospitals for chronic diseases or for veterans but not to provide care for these categories of patients in the facilities at the Medical Center. The devolution of many public health and social service functions to city and state agencies was in evidence as well, although Columbia was always eager to extend its academic programs at and

⁷⁵ Describing the explosive growth of private hospitals after the Civil War, historian Charles Rosenberg noted that, in terms of numbers, it paled in comparison to the expansion of the city's facilities. "At the close of the Civil War, for instance, New York's Commissioners of Public Charities and Correction were responsible not only for the sprawling, thousand-bed Bellevue Hospital, but also for a chronic disease hospital (Charity), smallpox hospital, fever hospital, infant or foundling hospital, and units for incurables and epileptics, paralytics and lunatics, as on Blackwell's Island, as well as a Children's Hospital and Idiot Asylum on Randall's Island. Bellevue alone treated 7,725 inpatients in 1866 and Charity, 7,574. And these figures were insignificant compared to the amount of outpatient care provided city's working people during the same year by New York's free-standing dispensaries, hospital outpatient departments, and the city's own 'outdoor' physicians." [Charles E. Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (New York: Basic Books, 1987), p. 110.]

with public institutions. Staffing and teaching on the hospital wards, however, entailed rather little responsibility for the institution as a whole even in private hospitals and even less so in public, for, until the last third of the 20th century, the physician's relationship to the proverbial 'doctor's workshop' was clearly such that he was in, but not of the hospital.

For the most part, public authorities at all levels of government looked favorably on private provision of health care as an unquestioned and unmitigated public benefit, as evidenced by tax exemptions, direct subsidies and payments to the voluntary hospitals for the care of indigent patients. It seems, however, that this long-standing 'complementary' relationship has created two levels of health care, as well as a clear hierarchy of health care investment, in which both the poor and the public interest are underserved.

Early Views on Institutional Development

In April of 1937, at the request of Presbyterian's Executive Vice-President, the Medical Board held a meeting to discuss the current structure and future needs of CPMC. The former dean of the Medical School, Dr. William Darrach, was asked to outline the original plan of the Center, focusing on the relationship between the School and the Hospital. In addition, the Board circulated a questionnaire to all heads of departments, whose responses were to be incorporated into a comprehensive report, to be written by the current dean, Dr. Willard C. Rappleye. The heads of departments were asked to comment on whether Hospital facilities were in balance with the present educational requirements and, if not, what additional facilities were needed. More specifically, they were asked if their requirements would be met by returning to ward status those beds which were currently reserved for semi-private patients.⁷⁶

⁷⁶ Lamb, p.320.

In keeping with their decision to look back at the original institutional goals, the Report reiterated that the Medical Center “was created to provide an integrated program for the highest quality of medical care for the sick and injured, to advance knowledge regarding the causes, prevention, and treatment of disease and disability, and to train young men and women for the professions of medicine, dentistry, nursing, public health and allied fields.”⁷⁷ Overall, the Review concluded that

[a] study of the early memoranda and plans for the Medical Center in the light of present needs and conditions clearly indicates the wisdom, flexibility and soundness of those plans. The extent to which the program has been realized can only bring deep satisfaction to those who made the Center possible because the original plan has been largely realized. There are no indications or suggestions for changes in the policies adopted in the beginning.⁷⁸

The report noted that the early vision of the Medical Center emphasized division of labor between the Hospital and the Medical School in which responsibility for all hospital activities should rest eventually with a single hospital organization for the entire Center, while the responsibility for all research and teaching rest with the University. With few exceptions, such arrangement had been achieved.

In regard to the overall size and the range of specialties represented at the Medical Center, the Report noted that

[i]n the original program there was agreement between the Presbyterian Hospital and the University that the former would endeavor to provide facilities for the instruction in general medicine and surgery for a student body of one hundred medical students per class. It was agreed that to satisfy these

⁷⁷ “Review of the Program of the Medical Center” (1937), reprinted in Albert R. Lamb, *The Presbyterian Hospital and the Columbia-Presbyterian Medical Center, 1868-1943* (New York: Columbia University Press, 1955), pp. 450-458 and discussed in Lamb, pp. 318-323 and Rappleye, pp. 34-37.

⁷⁸ “Review of the Program.”

conditions there should be 200 beds for medicine, 200 for surgery, and 250 for other specialties.⁷⁹

These expectations were linked with the hope that certain specialized hospitals would move to the Medical Center and, in the words of the Review, “[t]hat hope has been realized.”⁸⁰

Table 4.1 summarizes the number of beds designated for various medical specialties across the geographically affiliated institutions of the Medical Center in 1937.⁸¹

Table 4.1. *Number of Hospital Beds by Specialty at the Columbia-Presbyterian Medical Center, 1937*

Specialty	Beds
Medicine	118
Surgery	114
Obstetrics (Sloane Hospital)	131
Urology	45
Pediatrics (Babies Hospital)	147
Neurology	200
Psychiatry	200
Ophthalmology (Eye Institute)	53
Otolaryngology	29
Fracture	26

Source: Compiled from the “Review of the Program of the Medical Center” (1937), reprinted in Albert R. Lamb, *The Presbyterian Hospital and the Columbia-Presbyterian Medical Center, 1868-1943* (New York: Columbia University Press, 1955), pp. 450-458.

⁷⁹ *Ibid.*

⁸⁰ *Ibid.*

⁸¹ *Ibid.*

On the surface, it appears that the number of beds available to the various specialties was simply out of balance with the original conception. General medicine and surgery had many fewer beds than originally planned, whereas the number of beds in the other specialties was far greater than initially projected. The deeper reality was that the original conception of clinical training itself was altogether abandoned. Initially it was contemplated that all clinical instruction of medical students would be conducted at the Medical Center but, as the report put it, “although facilities for instruction in the medical sciences remain adequate for 100 students, it was realized early that this would not be practical or desirable for all phases of clinical teaching.” Several reasons were cited for this change of heart.

To provide all the facilities needed for a complete program would require a number of additional hospital units which would make the Medical Center too large for most effective management and would require more money for construction and endowment than has been available. A certain number of special services, such as those for tuberculosis and contagious diseases, would duplicate in large measure those maintained by the City The location of the Medical Center makes it difficult or impossible to provide for the many emergency problems of medical practice care for by institutions located in the congested and industrial areas of the City and especially the type of medical work in those institutions maintaining an active ambulance service. There was also a feeling that concentration of all activities at the Medical Center would tend to isolate the staff and the hospitals from their larger community responsibilities and would not satisfy the fullest public and professional purposes of the program. For these and other reasons it was decided that the major part of the undergraduate teaching should be given at the Medical Center, but that other hospitals would be utilized to supplement those basic facilities.⁸²

Clearly, the actual facilities of the Medical Center were very different from the 200-200-250 model contemplated at the beginning. It must be remembered that the period of the Center’s construction was one of rapid growth of medical specialties and

⁸² *Ibid.*

fundamental change in American medical education. Perhaps, then, the original model itself was found to be inadequate, although this was not mentioned in the Review. Table 4.2 summarizes the data on clinical instruction conducted outside of the Medical Center in the Review.⁸³ The document confirmed the general logic of the relationship of the (private) Medical Center with the public institutions of the City. Certain categories of disease – including tuberculosis and communicable diseases – were excluded from the Center’s purview in virtue of the lower-class stigma and greater perceived danger attached to them. The sole reason why the Medical Center would even contemplate provisions for these diseases was the “need at the Center for facilities for the care of those of the hospital staff and their families who may be ill with one of the communicable diseases” and a realization that there were “no satisfactory provisions in New York City for *private* patients with contagious diseases.”⁸⁴ This narrow construction of need was articulated despite the fact that Babies Hospital, as well as Departments of Medicine, Bacteriology, and Public Health, urged creation of facilities for communicable diseases.⁸⁵

Supplementation of clinical teaching at a broad array of other hospitals revealed yet another structural conflict at the Medical Center. At the time of the Report, the number of teaching beds available in Obstetrics and Neurology was far in excess of anything that might have been contemplated at the outset. The Sloane Hospital for Women had 131 beds, while the Neurological Institute had a whopping 200 beds. Thus, the beds available in these two specialties alone far exceeded the 250 beds originally contemplated for all specialties other than general medicine and

⁸³ *Ibid.*

⁸⁴ Lamb, p. 452, emphasis added.

⁸⁵ *Ibid.*, p. 457.

Table 4.2. *Clinical Instruction of Columbia's Medical Students Conducted Outside of the Columbia-Presbyterian Medical Center, 1937*

Institution	Public or private	Type of clinical instruction
Bellevue Hospital	Public	Physical diagnosis, 2nd year
Bellevue Hospital	Public	Rotation in medicine, surgery, and chest diseases, 4th year
City Hospital	Public	Elective courses
Hospital for the Ruptured and Crippled	Private	Orthopedic surgery
Memorial Hospital	Private	Cancer
Montefiore Hospital	Private	Neurological diseases and physical diagnosis
Morrisania Hospital	Public	Obstetrics
New York Orthopaedic Hospital	Private	Orthopedic surgery
Roosevelt Hospital	Private	Elective courses in medicine and surgery
Sea View Hospital	Public	Physical diagnosis
St. Luke's Hospital	Private	Elective courses
St. Vincent's Hospital	Private	Elective courses
Welfare Hospital for Chronic Diseases	Public	Chronic diseases
Willard Parker Hospital	Public	Contagious diseases

Source: Compiled from the "Review of the Program of the Medical Center" (1937), reprinted in Albert R. Lamb, *The Presbyterian Hospital and the Columbia-Presbyterian Medical Center, 1868-1943* (New York: Columbia University Press, 1955), pp. 450-458.

surgery. Why, then, did Columbia medical students had to go to Morrisania and Montefiore hospitals for additional instruction in obstetrics and neurology? The

problems with the integration of the Neurological Institute into the Medical Center went rather deep, although their exact nature seemed underspecified in the Report. At least a part of the problem was financial. The funds for full-time faculty were lacking and there was a critical need “for a moderate increase in free bed service in the wards over present provisions in order to permit a larger measure of selection of patients on the basis of their value in research and teaching rather than on their ability to pay.”⁸⁶ In regard to obstetrics, the Department’s feedback indicated that “more ward deliveries than can at present be provided in Sloane Hospital are necessary for the adequate training of the medical students.” While sending Columbia’s students to Morrisania Hospital for additional obstetrical experience was found advantageous, the Department nonetheless felt that the 17 obstetrical and 7 gynecological semi-private beds should be returned to the ward service. Only then the combined clinical facilities of Sloane and Morrisania “would provide approximately enough material for the instruction of a student body of the present size.”⁸⁷

Situation in obstetrics and neurology bespoke the conflict between the goals of teaching and private hospital service. In both cases, effective instruction required massive numbers of poor ward patients which could be used for teaching. While the availability of great numbers of suitable ward material was a priority of the Medical School, the private hospitals – in this case, the Sloane and the Neurological Institute – clearly had somewhat different priorities which included paying patients unavailable for teaching and possibly also the modes of selection and treatment of ward patients which did not primarily maximize their value as teaching material.

The report from the Department of Dermatology revealed yet another line of structural conflict within the Medical Center. Unlike urology or ophthalmology which

⁸⁶ *Ibid.*, pp. 451-452.

⁸⁷ *Ibid.*, p. 456.

received their own floor and building respectively and reported being satisfied with their facilities dermatology felt grossly neglected. Only six hospital beds, previously assigned to general medicine, were allotted for dermatology and the Department of Medicine actually wanted the beds returned for its own needs. Department of Dermatology, meanwhile, argued that no less than “a unit of 40 beds should made available for undergraduate and graduate instruction in that subject.” Moreover,

It is felt highly desirable that hospitalization should be provided for the purpose of treatment of certain cases, particularly those with syphilis, for diagnostic problems and for clinical research. A certain number of special facilities would be needed such as an allergen-free chamber, special beds for certain types of diseases, several treatment rooms for electrical and minor surgical procedures, a unit for actinotherapy, one for X-ray therapy, and another for fever therapy, together with necessary offices and conference rooms for the staff.⁸⁸

While the Report recognized that no less than a large part of an entire hospital floor was needed to realize these plans, in the immediate future the demands were given a rather short shrift. It concluded by saying that “[m]ost of the instruction of undergraduate students in this specialty can be given satisfactorily in the out-patient department” and that “[t]here [was] no great need of hospitalizing patients for the purposes of such teaching.” The real need for hospitalization, it admitted, stemmed from research.⁸⁹

The report on dermatology revealed another facet of divergence between teaching and research. The original conception of the Medical Center boldly asserted the structural dependence of teaching, research, and care of patients upon each other for the achievement of highest quality in each. Conflict between teaching and care of patients were already apparent but even research and teaching needs did not

⁸⁸ “Review of the Program.”

⁸⁹ *Ibid.*

necessarily coincide. When the social stigma entered into the picture, as was the case with syphilis and other 'skin' diseases, the very definition of needs – being it for research, teaching, or treatment – were deeply impacted.

Even as all these contradictions were implicit in the Report, the great myth of the Center's structural purpose – that of the derivation of the size and structure of the Medical Center from the task of providing high quality medical education for 400 students – persisted. Two factors tended to explode the myth. The first was the rapid evolution of ideas about medical education that was fueled, in turn, by the rapid changes in the nature of medicine itself. The second and less benign was the realization that scientific progress and practice were dependent on funding. Just as the development of medical centers as such required enormous funding, greater development of some areas of specialization – such as ophthalmology and urology at Presbyterian – were predicated on complex interrelations among professional prestige of the specialty, personal status of the practitioners, social status of the patients, and individual interests of the donors.

The deficits created by the semi-private accommodations and the critical need to expand Dermatology were the clear implications of the Review, yet nothing was really done about either problem for another two decades.⁹⁰ Even less attention was given to the fact that the Center did not in fact fulfill its purpose of providing comprehensive, one-location facility for clinical instruction of medical students. Clearly, students' convenience was not the leading rationale of institutional structure and neither was there a real need of bringing in geographical proximity all of the various medical specialties for either research or treatment purposes. Thus, only the more prestigious specialties were located at the Center, in which the current medical

⁹⁰ Lamb, pp. 323, 332; Rappleye, pp. 45-46.

staffs were professionally interested. In the absence of professional interest, neither community responsibility, nor students' convenience would bring to the Center those specialties – like tuberculosis, syphilis, or contagious diseases – which were assumed to be natural preserves of the City's institutions.⁹¹

Yet this failure was instructive, both for the Medical Center and for American medicine more generally. The idea of the university medical center did not break the lines of interest which pulled the various parts of 'the teaching-research-and-care triad' in different directions. The prestige of being associated with a private hospital powerfully motivated the professional staffs at the elite medical centers. At its root, this was still an old-fashioned phenomenon of the practitioner's prestige being dependent on the social status of his clients. Association with elite private hospital allowed physicians to avoid serving the worst kinds of patient populations, those relegated to public institutions. Equally important was the fact that the Medical Center's professional staff had also retained a right to continue with lucrative private practice among the social elites.⁹² Yet a private hospital or even a broad collection of private hospital assembled in one geographic location was in many ways not ideal teaching environment. Despite the enormous number of ostensibly 'teaching' beds gathered at the Medical Center, Columbia's medical students had to be sent to a large number of other hospitals, both public and private, to supplement their clinical instruction. This surprising deficit of 'teaching material' highlighted the selective care practices of private hospitals, as well as a divergence of interests between private hospital care and medical research, on one hand, and medical education, on the other.

⁹¹ Those specialties which were soon added to the Medical Center were instructive as well. Orthopedic surgery, whose prestige was helped enormously by WWII, came to CPMC after the war. [Rappleye, p. 45.] Cancer, although dreaded and stigmatized, was brought to the Center, albeit in the form of a public hospital. Neither contagious diseases, nor skin and chronic diseases were given extensive facilities until much later.

⁹² This is the subject of Chapter 2.

As the status of certain medical specialties at CPMC made clear, research interests were often in conflict with teaching needs and hospital policies, while all three were powerfully determined by socio-economic and status associations of diseases and patients.

Not only did the myth of structural unity derived from an educational commitment persisted through the 1937 Report, it was found useful in the future reviews and critiques of the Center's development. In 1945, Dr. Albert Lamb wrote a report entitled "The Program to Place the Various Activities of the Medical Center in Balance" at the request of the Medical Board. Standing at the close of this career, Dr. Lamb's report opened on a more pensive note.

All of our original and subsequent plans have not been accomplished. Perhaps it is just as well that some of them have not been. Some have been dropped or altered materially. Too often *expediency* has dictated out policy without sufficient consideration of how the expedient thing, however satisfactorily it seem to meet the requirements of the moment, would alter or block future essential and correct moves. ... Even if we [plan] to the best of our ability some things will be overlooked and emphasis will be misplaced. This possibility serves to bring out a point of utmost importance, i.e. *planning for the Medical Center should not be sporadic*.⁹³

Dr. Lamb hoped that the institution's present program was indeed "one of bringing the activities of the Medical Center into *reasonable balance* rather than as a program of *expansion*." Quality, not size, was the ultimate goal and an institution could become too large and unwieldy.

Size is the thing with which the Planning Committee had had to contend ever since it began work. Wherever we turned there was request for more space and still more space for possible future expansion. The reason which was given

⁹³ Lamb, p. 408; emphasis in the original.

was generally that there was such an increasing demand from so many patients that two to four times as much space was needed as it now available.⁹⁴

In Dr. Lamb's opinion, "this point of view totally disregard[ed] the principle that services should not be larger than necessary to carry out the fundamental concepts upon which the Medical Center was put together. Patient demands in themselves must not dictate out fundamental policy, and no one activity should be dominant." Any service – be it plastic surgery or arthritis – can grow to any size. Low-cost private patients could fill a facility two to three times larger than the one contemplated. Yet, argued the report, "[w]e feel certain that we do not want such an unbalanced program."⁹⁵

Though clearly concerned with the pressure stemming from 'patient demands,' the Report reserved special ire for another factor threatening institutional balance – community service.

There is a great surge, at present, toward various types of expanded community service. We believe this trend is as it should be, if kept within reasonable and practical limits, that it will continue, and that the Medical Center should play its full part in this field. The pertinent problem is "How much of this community service should one hospital carry?" The whole Medical Center could be devoted to this one end. Then what becomes of the concepts upon which the amalgamation between Columbia University and the Presbyterian Hospital was based? We shall play a much more useful and important part in the medical education of the present and the future if we adhere to our original concepts and fit the various phases of this community service into our picture than if we allow these things to dominate our policy.⁹⁶

⁹⁴ *Ibid.*, p. 409.

⁹⁵ *Ibid.*, p. 409.

⁹⁶ *Ibid.*, p. 410. This was not an isolated sentiment. The Dean of the Medical School, for instance, wrote the following on the occasion of the 25th anniversary of CPMC in 1953. "Fully aware of the many and diverse responsibilities which revolve about the health services in the community and the national which the several professions must carry, the University has rendered its most important and broadest public service through the maintenance of a high level of professional education in the health sciences and concentration upon the primary purpose of real education – the stimulation and encouragement of first-class minds and intellectual effort. It can and should carry its share of the obligation for hospital services, the continued training of practitioners, and the preparation of

In response to these threats to institutional balance, the document made the following suggestion. On the immediate and practical side, it recommended “providing more facilities for medicine” and “using the rest of the evacuated housing space for comparatively small research units for specified periods of time and with proper grants for such work.”⁹⁷

On the longer-term policy side, Dr. Lamb’s review recommended trying to stick to “the fundamental concepts upon which the Medical Center was put together and not be influenced by any demand for expansion beyond such concepts.” These concepts were as follows, in the order of listing:

(1) Services of the size essential to teach classes of 100 students at P&S – never more, preferably less.

(2) An Out-Patient Department – Vanderbilt Clinic – with services of the proper size to supply suitable and adequate material for the wards, for teaching in the O.P.D., and for research there. In addition there should be facilities for proper ambulatory diagnostic service, follow-up clinics, care of students, personnel and compensation cases, and some special clinics carefully selected and supervised. An O.P.D. organized in this way will carry out its other important functions – service to the community and to the doctors in the community.

(3) Research facilities for the different services adequate to carry on this most important part of our program.

(4) Adequate laboratory and teaching facilities in the Medical School to care of all of the routine work and research activities.

(5) Facilities for the care of private patients above ward rates and ambulatory and bed cases, to allow those doctors devoting an essential part of their time to the various necessities of the Hospital to do so at a minimum of stress and strain.

(6) A Training School for nurses of not over 100 to a class to provide adequate nursing training and to care for the hospital program as out-lined above.⁹⁸

specialists. Its greatest contribution, however, is to educate men and women to meet these responsibilities, rather than assume direct management of community services, except those necessary to discharge its function.” [Rappleye, p. 78.]

⁹⁷ Lamb, pp. 409-410.

⁹⁸ *Ibid.*, pp. 410-411.

The recommendations created an impression that a proper size and structure of the Medical Center had to be derived from an imperative to teach 100 medical students per class. Yet even the list that followed undermined this structural clarity. The connection between teaching and research in terms of institutional size was not even attempted. The extent of the research facilities was described only as “adequate” for “the different services.” While declared “[the] most important part of our program,” research was listed third, not first, in this hierarchically and logically arranged program. Non-ward patient services were derived from the desire to minimize commuting for doctors, while their subsidy of physician’s and the Center’s incomes went unrecognized as a root of possibly discordant interests. Emphasis on training medical and nursing students – to the exclusion of students in public health, administrative medicine, and other allied fields – hid unacknowledged emphasis on functional cross-subsidies, such as the use of nursing and medical students in actual patient care, which also influenced institutional policies.⁹⁹ Recognition of separate obligation to serve the community and community’s doctors did nothing to ask what influence the Medical Center had on the medical services available to surrounding community, what dynamics structured the surrounding community, and what the community’s changing needs and expectations were.

Conclusion

As the nation’s first Medical Center, Columbia-Presbyterian embodied an idea long championed by the most visionary medical minds. The concrete realization of this idea had repeatedly tested its coherence. The fundamental expectation of creating a class of full-time researchers and professors, freed from the burdens and temptations

⁹⁹ Dr. Lamb has extensively covered this problem in his history of the Hospital, openly stating in his criticism of the Hospital’s policies that “to require the student nurses to perform work far beyond that needed for their education comes close to exploitation.” [Lamb, p. 318.]

of private practice, had been decisively defeated at Columbia. The actual building and early expansion of the Center revealed further challenges to the institutional vision.

By far the most visible conflict during the construction period involved the Out-Patient Department. To the astonishment of many, one of the early plans for the outpatient clinic envisioned a thirty-two-story building. While elated, the interested member of the professional staff sensed dangerous delusion at work. They were right and the air castle had quickly collapsed to whatever could be built with the remainder of construction funds – a structure of one and a half floors. Horrified at this reversal and convinced that no outpatient clinic would be better than this ‘abortion,’ a few determined physicians made a terrific fight for an adequate building. This early incident pointed toward a more systematic contradiction. It was broadly recognized that the outpatient department was a very important part of a teaching hospital. Its size had to be carefully determined because it crucially determined the ability of the teaching hospital to secure an adequate number and kind of ward patients to be used as teaching material. At the same time, the actual work at the outpatient clinic carried a low professional prestige and was relegated to younger and less successful physicians. Given this contradiction, the outpatient clinic was bound to settle for a minimal acceptable functioning, without regard to patient comfort or service standards. The low quality of outpatient care bred dissatisfaction among those who worked there. Sooner or later, substandard outpatient services were also bound to provoke an outcry from the patients and the community.¹⁰⁰ At the heart of the outpatient problem were many structuring divisions: patient social class, professional medical hierarchy, general versus specialized care, academic versus community physicians, and so on. Their varied confluence carved out some predictable and some unusual interests in

¹⁰⁰ This is a subject of Chapter 6.

regard to outpatient services. Besides those who actually worked at the outpatient clinic, member of particular departments, including medicine, pediatrics, and orthopedic surgery, were more interested in adequate outpatient services. OPD 'alumni' who moved on to higher professional posts were also more concerned.

A similar problem arose after the completion of the Medical Center. One of the most acutely felt deficiencies of the new Center was a lack of arrangements for the so-called "semi-private," whose accommodations and hospital rates lay somewhere between ward and private-room patients. Despite a serious effort to study the problem and propose a solution, the Medical Center had failed to fix the problem either in terms of physical accommodations or by way of novel financial arrangements. Again, conflicted interests and a weak constituency in support of change was involved. 'Semi-private' patients were not useful for either teaching or generation of revenue for the hospital and physicians. As paying patients they were excluded from examination by or in front of students and interns, while their fees and collection problems ensured that the hospital just about broke even. The exception were the younger doctors who often depended on 'semi-private' patients to build up their own private practices. As the number of such patients grew, 'semi-private' accommodations became of larger public interest. With the rise of private hospital insurance, the problem of the 'semi-private' patients was soon intertwined with one of insurance and compensation plans. Increasingly, the 'semi-private' patients were the derisively called 'compensation cases.' Columbia-Presbyterian's records suggest that the widespread opposition to any negotiated hospitalization plans contributed to the failure to deal with the 'semi-private patient' problem. Not until much later were measures taken to provide adequate accommodations for this growing group.

These 'patient-determined' institutional divisions were only the tip of the iceberg. As the Medical Center took shape, the patterns of geographical and non-

geographical affiliation presented a rich picture of diverse and disparate structure of medical care. An early decision to integrate with Presbyterian two previously independent hospitals specializing in obstetrics and pediatrics, as well as internal reorganization of Presbyterian's social work and public health departments, were part of a larger 'end of an era' of the 19th century institutions founded and funded by women. Decisions to bring some hospitals into geographical proximity, while affiliating with others at a distance for the purpose of clinical instruction, revealed a complex logic of professional prestige, social stigma, and philanthropic whim.

The hierarchies reflected their time and place. The Center's psychiatric hospital was a public institution and so was its cancer unit. Reflecting the dread and stigma attached to cancer at the time, the hospital in question would have been located on Welfare Island – along with the hospitals for contagious, chronic and mental diseases – had the CPMC not timely shown sufficient foresight into the future of oncology. Other affiliations – involving tuberculosis, chronic, contagious and sexually-transmitted diseases – were never pursued. These and other affiliations revealed not only a hierarchical arrangement of specialties and patient pools within medicine but an intimate relationship between the private and the public institutions. Not only were the public institutions expected to provide the care for the patients and diseases of the worst kind, but the private institutions tremendously benefited from the ready ability to 'affiliate' with them for the purposes of clinical instruction. Whether the public patients and American medicine as a whole had reaped benefits from this arrangement remains questionable.

While various 'deficiencies' and 'imbalances' were recognized in early reviews of the Medical Center's development, Columbia-Presbyterian's leaders clung to the vision of coherent institutional purpose. One such vision was rooted in 'preventive medicine' and 'community service.' While the former was clearly not a

priority of either this institution or American medicine as a whole, the latter was soon repudiated, unless by it was meant the Center's primary educational purpose. But even this more focused and pragmatic mission was belied by divergent interests and incentives. Early reports spoke of harmful pressures of 'patient demands,' which in reality may have been just as much those of providers. Despite efforts at rhetorical coherence, research appeared to be largely independent from either teaching or patient care. Early on, it was largely driven by philanthropic funding, institutional imperative, and professional prestige. Like patient care, research showed tendency to develop independently from the needs of teaching.

The premonition of structural discord had deeper roots. Early in the Center's history, it became clear that, besides the 'full-time' principle, another fundamental idea went unrealized. Originally, it was envisioned that all clinical instruction should be concentrated at the Medical Center but very soon Columbia's students were completing part of their training at a dozen other hospitals in the City. The reasons were complex and understandable, yet this adjustment revealed that the institutional structure had a logic other than that which was contemplated at the beginning. That the educational mission was not the unifying element of the institutional structure may not come as a surprise but the other theories of organizational logic proposed to explain the genesis and functioning of academic medical centers are not supported by evidence either. Above all, the process of building and expanding the nation's first medical center demonstrated substantial complexity of professional and institutional organization. Although frequently hierarchical, this organization is not reducible to either the dominance of the medical profession, nor the capitalism-promoting mission of the corporate philanthropies. The medical profession was too significantly fragmented and caught up in a web of complex relations with other institutions and actors. To analyze the politics of the first medical center, we need a level of analysis

which is both bigger and smaller than the profession and is sensitive to institutional embedding of health care professions. The concept of institutional class positions proposed in this dissertation aims to provide such a tool. It refuses to see professions as monolithic, undifferentiated formations, pointing out significant differentiation among their different segments. It applies larger categories of class, gender, race to break the monolith of the profession and situates these professional fractions within their institutional and career settings.

It is through this analytical lens that we can see that the struggle for out-patient and 'semi-private' services was structured by different kinds and degrees of interests, rather than by the politics of the medical profession as such or the institutional policy of the medical center as a whole. This theoretical perspective also helps us deconstruct the purported trinity of education, research and patient care placed at the conceptual foundation of the academic medical center. Not only did the education, research, and patient care entail different investments, interests and incentives, but they themselves broke down along the lines of specialty, disease, institutional embedding, and donor interest.

The planners at Columbia-Presbyterian sensed the strong possibility of unchecked and incoherent growth of the various parts of the Center and their efforts to impose a purposive coherence to institutional development are instructive. Seen as a field of institutional class positions, the process of building and planning the Medical Center is a good illustration of the private health care environment. In it, micro-inequalities of the professions and institutions are deeply rooted in the macro-inequalities of social class.

CHAPTER 5

IN A CLASS OF THEIR OWN: WOMEN AND MINORITIES IN MEDICAL SCHOOL ADMISSIONS AND EDUCATION, 1891-1980

Introduction

In the past several decades, scholars working in diverse disciplines have done much to reconstruct the history of women and minorities in the various institutional and occupational fields. Much excellent research has been done on women, African-Americans, and other minority groups in medicine and the related fields of biomedical sciences, public health, nursing and health care administration. This work – and the larger goals of diversity which propel it – holds vital importance for the American health care system, impacting everything from health outcomes for different socio-economic groups to the structure and course of health care politics.

Studies of women and minorities in medicine and related fields have contributed tremendously to placing race, gender, and ethno-religious identity alongside class, occupation and institutional structure (bureaucracy) as fundamental elements in the making of the social fabric. While one result of these efforts has been a picture of social space characterized by higher complexity (and, hopefully, by higher fidelity), there has also been a notable lack of theoretical synthesis of the new findings into more coherent narratives of social structure.

Most work being done is still concerned with one or two dimensions of social division (gender/occupation; race/institutional structure) with no more than a nod of acknowledgement given to others. Exquisite sensitivity to the multiple lines of division often coexists with an unwillingness to question the analytical validity and integrity of such received concepts as the profession or professional power. Even the

work devoted to the intersectionality of class, race, and gender has mostly failed to acknowledge the deconstructive implications of its own paradigm. Overall, most of us still see several classes, a couple of genders, a number of racial and ethno-religious groups (depending on the historical context), a list of occupations, and a chart of institutional fields as workable images of the social space.

This chapter uses an investigation into the practices of admission to medical school and professional employment at one of country's oldest academic medical centers to question this simple conception of the social structure.¹ The main topic of this chapter is the subject of gender, race, and ethno-religious discrimination in the medical school admission, understood in a broader context of selection, training, and employment in health care field. I focus particularly on the period of over half a century between the late 1910s and the early 1970s, when both women and minorities were admitted to Columbia, as well as most other medical schools, but on highly unequal terms. My principal contention is that, if entering medicine is synonymous with entering a range of positions within the middle and upper-middle class, women and minorities have not entered medicine until the 1970s or even not yet. I show that what they did enter were different and differently constrained structures of occupational, institutional, and social positions which existed alongside, not within, the structures open to the profession's white male majority. In other words, as I show

¹ Unless otherwise indicated, all primary materials pertaining to the admissions practices at the Columbia University College of Physicians and Surgeons have been found at the Health Sciences Division Archives of Columbia University housed at Archives and Special Collections, Augustus C. Long Health Sciences Library, Columbia University, 701 W 168th Street, New York, NY. On women, primary sources were Folder 54, "Women in P&S, 1921-1961," and Folder 54, "Women in P&S, Current." On the subject of the charges of ethno-religious discrimination, primary sources were Box 623, "Discrimination 1946-1950s," including Folder 623, "Discrimination in Medical Schools, 1945-1946;" Folder 623, "Discrimination in Medical Schools, 1947-1949;" Folder 623, "Discrimination in Medical Schools, Current;" Folder 623, "() Newspaper Clippings;" and Folder 623, "() Proceedings (Hart – Goldstein – City Council)." Information on African-Americans was drawn from Folder 551, "Negroes" and Folder 551.1, "Negro Students." Many documents have been copied and are in the author's possession; the rest were transcribed in Research Notebook 2.

on the example of Columbia-Presbyterian Medical Center, there are existed separate structures of social class positions, constituted within the field of health care occupations, into which majority women, minority men and minority women were routed.

It is tempting to conclude that racial minorities and women were confined, as it were, to the back of the medical bus but that, too, would be an oversimplification. Whenever the formal practices of exclusion were defeated, some, usually the exceptionally gifted, women and minorities were permitted in the front section, even if extra and less comfortable chairs had to be added to accommodate them. Thus, we have an analytical conundrum, where gendered and racialized practices systematically confined women and minorities to a distinct structure of occupational and social positions, yet this structure did not nevertheless amount to a separate – women's or black – sphere in medicine.

This puzzle calls for a novel analytical framework of 'class-institutional positions' proposed in this dissertation. It is not simply that there are what a historian Ellen More termed "composite roles" at the intersection of woman/physician or African-American/physician but that the structure of the medical profession as a whole falls apart into multiple social positions comprehensible in terms of differential relationships to power and privilege. Despite the elegant analyses of its professional power and organization, academic medicine has been and continues to be an ensemble of hierarchical structures headed by multiple elites. The histories of those who have been most blatantly excluded illustrate the processes of division and exclusion most vividly; but even the stages through which the provisionally included members are put

through indicate the definitive hierarchicalism and particularism of the professional structure.²

Throughout the chapter, I pay special attention to the very pronounced differences in the construction of unequal and discriminatory terms, on which female, ethno-religious minority and racial minority applicants were admitted to Columbia's medical school. Women were officially barred from Columbia's College of Physicians and Surgeons until 1917 and for the following five decades comprised less than ten percent of students. Formally, there was no discrimination in the admission process, as female applicants were admitted at about the same rate as male. The delimitation of the women students at Columbia, as in most other institutions, was accomplished by means other than those pertaining directly to the admission decisions. In the decades before and after World War II, members of some ethno-religious groups, particularly Jews and Catholics, encountered well-documented discriminatory practices in medical schools, as well as other educational and professional institutions. The situation was especially appalling with respect to the Jewish applicants in New York City, where the community was very large and had a disproportionate number of well-qualified students. Unlike the fair sex, the Jewish community did not limit the number of their applicants to the proportion with which the medical schools were comfortable. Against this group of applicants, the medical colleges practiced direct forms of discrimination, admitting them at the rates much lower than those for the similarly qualified gentile applicants. But the worst situation – at Columbia and everywhere else – was reserved for the African-Americans. Although not formally barred from admission, until the 1970s black students were both extremely rare and largely invisible. Despite some statements to the contrary,

² Both hierarchicalism and particularism are assumed here, as in much democratic theory, to be incompatible with equal membership.

Columbia did not make particular efforts to recruit, educate, or recognize African-American students and physicians.

The differences in discriminatory practices adopted in regard to different social groups are often attributed to the different situation of these groups. There is some truth to that but they also reveal the variety of both discriminatory and affirmative mechanisms which medical institutions have at their disposal. This part of my analysis leads to the chapter's second, and partially normative, point that institutions bear responsibility for their membership. I conclude that careful and innovative investigation of discriminatory and inequitable practices of institutional exclusion in the past can help us formulate more socially responsible approaches to institutional membership of the future.

Gender

In colonial America, most medical care was routinely provided by women in the home. Women were also prominent as lay practitioners. By the Jacksonian period, however, women's prominence as both lay healers and as midwives began to wane. Traditionally, women practiced where male doctors were absent and, as the number of male doctors began to rise, the women practitioners became displaced. The rise of modern medical professionalism provided both obstacles and opportunities for women.³ The emergent emphasis on formal medical training and certification established a powerful mechanism for categorical exclusion of women from the profession. At the same time, the growing standardization of training and certification provided a more focused field of battle for those determined to win women a place in medicine.

³ This development must be seen as a part of the larger process which commenced after the Renaissance and saw the wholesale expulsion of upper and middle class women from public and professional pursuits.

In 1849, Elizabeth Blackwell became the first American woman to earn a degree from an established medical school, but women's right to medical education has been far from firmly established. In fact, "[t]he graduation of Miss Blackwell from Geneva Medical College in 1849 aroused such general condemnation among the medical fraternity throughout America that the experiment was not repeated, Elizabeth Blackwell thus being the first, and for many years the last, to graduate as Doctor of medicine from a regular New York medical school."⁴ The few women who followed graduated predominantly from homeopathic, eclectic and other sectarian schools which were less subject to ostracism from the side of the chauvinistic fraternity of medical men. Nevertheless, through the efforts of these pioneering women, several women's colleges of medicine were established after the Civil War.

The first such school, the New England Medical College, was founded in Boston in 1848 and was the first medical school exclusively for women in the world. In all, seventeen medical colleges for women were founded in the United States the second half of the 19th century and their founding had a considerable effect on women's participation in the medical profession. Between 1880 and 1890, the percentage of doctors who were women increased nationally from 2.8 to 5.6. In some cities, the proportion of women was considerably higher: 18.2 in Boston, 19.3 in Minneapolis, 13.8 in San Francisco. With more than 7,000 women physicians at the turn of the 20th century, the United States was far ahead of England, which had just 258, and France, which had only 95.

Despite this progress, most regular schools of medicine – and especially the elite institutions – remained uniformly closed to women and the country's second

⁴ James Sullivan, ed., *The History of New York State* (Lewis Historical Publishing Company, Inc., 1927; Online Edition by Holice, Deb & Pam), Book 12, Chapter 13, Part 6, on the web at <http://www.usgennet.org/usa/ny/state/his/bk12/ch13/pt6.html>

oldest institution – Columbia’s College of Physicians and Surgeons – was no exception. No woman has been ever been admitted to its courses since its opening in 1767 as part of the King’s College and a century a quarter later, the school officially affirmed its desire to continue this policy of exclusion. The decision was occasioned by the movement toward a closer affiliation between the University and the medical school.⁵ The agreement, eventually reached signed by the two institutions, was notable for containing two provisions that allowed the medical school to nominate its staff and also to refuse admission to women.⁶ That the issue of women’s admission was included within the agreement was not so much an indication of the medical faculty’s particular conservatism or the University’s progressivism, as the fact that the battle for women’s access to higher education has begun in earnest. In New York City, the battle was particularly fierce, for a number of reasons.

New York City, as well as the East more broadly, was hardly a pioneer in women’s education. The first coeducational college was Oberlin of Ohio which admitted four women to special courses in 1837. A few female seminaries were opened after that, including Mount Holyoke which opened in the same year. Philanthropic brewer Matthew Vassar made it possible in 1861 for the college named for him to pioneer. After that, a handful of men’s colleges let down the bars in the 1870s: Cornell, Michigan, and Boston allowed girls to take courses. Two more

⁵ This development was typical among the top-rate institutions at this time, taking place at the same time at Harvard, Princeton, Cornell and others, and both sides of this development – the medical schools and the universities – had compelling interests in the matter. The universities, undergoing a period of becoming equal to their designation, were trying to bring closer into its orbit – or to establish from scratch – the requisite assortment of professional schools and graduate disciplines. The medical schools, no longer considered excellent without the effective university and hospital affiliations, sought the aegis of the university, including the infrastructure and resources to bolster their basic science departments. (Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982), pp. 112-116.)

⁶ Albert R. Lamb, *The Presbyterian Hospital and the Columbia-Presbyterian Medical Center, 1868-1943* (New York: Columbia University Press, 1955), p. 73.

women's colleges – Wellesley and Smith – were established in 1875, while Mount Holyoke Seminary had become a college in 1893. Harvard Annex, which later became Radcliffe, opened in 1879. New York City, however, did not have a single institution that would grant college degree to a woman. A Normal College, connected with the free City College, offered some training for teachers, but granted no degree. Some private girls' schools in the city have high social standing, but did not amount to much academically. Other cities – including Boston, Baltimore, Philadelphia and Chicago, St. Louis, and even New Orleans – had better provision for educating women than New York and a number of citizens and citizen groups began advocating for the cause.⁷

Under the influence of these advocates, as well as in virtue of his own upbringing in a family of strong women, Columbia's President Barnard became an outspoken champion of college education for women. In this, however, he had few supporters and many opponents, including most of Columbia's trustees and members of the faculty. According to the memoir of Columbia's later President, Barnard's annual report for the year of 1879 "created a panic by advocating the admission of women to Columbia College."⁸ Undaunted, President Barnard continued to make this recommendation with renewed vigor in the reports for 1880 and 1881. Butler 76 His advocacy was seen as so dangerous, that "the trustees went so far as to decline to permit President Barnard to print, without their previous censorship, one of his Annual Reports because of the vigorous arguments it contained in support of his

⁷ Horace Coon, *Columbia: Colossus on the Hudson* (New York: E.P. Dutton & Company, 1947), pp. 189-190.

⁸ Nicholas Murray Butler, *Across the Busy Years: Recollections and Reflections I* (New York: Charles Scribner's Sons, 1935), p. 76.

recommendation that women be admitted to Columbia College on equal terms with men.”⁹

Predictable arguments were sounded against higher education for women. Reverend Morgan Dix of Trinity was horrified by the gathering movement and declared that “the education would destroy the modesty of women.”¹⁰ Very soon a racial card was thrown into the fray. While President Barnard continued to agitate for co-education at Columbia, powerful forces led by Professor John W. Burgess declared that if Columbia became co-ed the young ladies admitted would likely be Jewish, and that would make Columbia’s student body predominantly Jewish. This unscrupulous raising of the racial issue had the effect of arousing the alumni in loyal support of Burgess.¹¹

The pressure from some citizen groups continued and in 1883 the College reluctantly established what came to be known as the Collegiate Course for Women. The Course would grant a degree to those who would pass the examinations, except that the women were barred from attending lectures, on which the examinations were to be based. Although a good number of women signed up for the Course, only a few succeeded in earning a degree, since they had to pass examinations without having had the opportunity to sit in on any of the lectures.

With true co-education being a battle that could hardly be won, the strategy adopted by the advocates of women’s higher education was one of persuading Columbia to establish a separate college for women. One of the alumnae of the Collegiate Course, Annie Nathan Meyer, spearheaded a vigorous campaign of publicity, persuasion, and fund-raising and in 1888 Columbia’s trustees were prevailed

⁹ *Ibid.*, p. 80.

¹⁰ Coon, *Columbia: Colossus on the Hudson*, p. 190.

¹¹ *Ibid.*, p. 192.

upon to agree to the establishment of a separate annex for women on the model of Oxford's Girton, Cambridge's Lady Margaret Halls, and Harvard's Radcliffe.

The momentous event coincided with President Barnard's death and the new college was named after him. To some, this was the most appropriate recognition of his early and courageous advocacy of women's education. Others judged it as an ironic and callous insult to his memory, for he had strictly insisted on co-education and opposed separate institutions for women. Columbia's trustees laid down appropriately unjust conditions concerning the new women's college: it was to be built and operated without any financial assistance from Columbia, but Columbia would have a controlling share of power in its governance.¹²

While of historic significance, the establishment of the Barnard College was not recognized by Columbia's faculty as either the fact of, or even a step toward, co-education. A telling evidence of this was the chief reason given in the report of the University Council on the proposition for consolidation of the New York College of the Training of Teachers (now the Teachers College) with the University. The proposal came at a time when the Columbia College was implementing closer affiliation with the Law School and the College of Physicians and Surgeons in a quest to become a true University and the committee agreed that the school was "doing most excellent work of a character that is in part, if not as a whole, germane to the work of a university." However, the consolidation on the pattern of the law school or the medical school, was soundly rejected by the committee.

Two reasons influence your Committee to report against this plan. The first reason is that a necessary part of the organization of the College for the Training of Teachers is a school of observation and practice, in which every grade from the kindergarten to the high school must be represented. The maintenance and administration of such a school as part of Columbia College

¹² *Ibid.*, pp. 193-194.

would involve many difficulties, and would very distinctly divert our administrative energy from its proper channel.

The second reason is that such a consolidation as is proposed would introduce co-education into Columbia in a most pronounced form. A large majority of the students in the College for the Training of Teachers are women, and this will always be the case. In this county more than sixty per cent of the entire teaching force are women, and the proportion is increasing. We believe that at this point in our development, when Columbia is becoming a university, and is laying the foundations of its reputation as such, it would be a mistake to commit the university to a policy of co-education, as such a consolidation would commit it. Either of the reasons given should be sufficient in our view to prevent consolidation, and both together seem to form an insuperable obstacle.

At the same time it is not to be denied that an alliance between Columbia and the College for the Training of Teachers might be formed that would be of advantage to both. ... For such an alliance we believe that Columbia's arrangement with Barnard College, with certain necessary modifications of detail, furnishes the correct type.¹³

Thus, the medical faculty's decision in 1891 to exclude women was not as much out of step with their parent University as may appear. Their reasons, beyond sheer prejudice, were probably similar to the reasoning which balked at the proposed affiliation of the Teachers College. At the time when the College of Physicians and Surgeons was making rapid progress toward elite national reputation, admission of women would exert very likely imperil its standing. Thus, the inclusion of the specific provision granting the medical faculty the right to deny admission to women was not so much out of step with Columbia at large, as an indication of a fear that some or even all of the parts of the Columbia University might be compelled to admit women sooner rather than later and a precaution against being dragged into co-education along with it.

¹³ Butler, *Across the Busy Years*, pp. 182-183. According to President Butler's memoir, the establishment of the Teachers College had much to do with President Barnard's pioneering vision of teaching as an academic and professional field and of the equal access to higher education for women. Butler himself was apparently an early convert to both of these causes and one of the principal contributors to the progress on women's education at Columbia and in New York City after President Barnard's death. (See especially Chapter VIII, "Founding Teachers College," pp. 176-187.)

If the question of women's access to medical education was importantly constrained by their limited access to higher education in general, another determining factor was women's participation in the professional field of medicine more generally. Of particular importance was women's role in the work of the hospitals, which were rapidly emerging as central institutions of both professional training and practice.

Despite the outstanding contribution of women to the modernization of the 19th century hospital, their subsequent role in hospital administration and nursing fell short of providing the necessary foundation to support women's progress in medicine. During and after the Civil War, the American counterparts of Florence Nightingale have done much to improve the organization of hospitals, first military and then civilian. Part of a larger movement of women's social activism and philanthropy, the work of these pioneers was equally concerned with administration of hospitals and social service, as it was with bedside nursing. This broader agenda was reflected, for a while, in the increasing numbers of women superintendents during the second half of the 19th century and the absence of the strict separation between administration, social work, and nursing in the hospital work. The three fields, however, soon began to diverge, in unmistakably gendered terms. Administration increasingly separated from nursing and was turning into a male-headed hierarchy. Nursing, in contrast, was swiftly undergoing a total feminization and assuming a clearly subordinate position to both administration and medicine. Social work was also shaping up to be a largely female preserve, with a rather uncertain place both in medicine and the hospitals.

As far as Columbia's College of Physicians and Surgeons was concerned, the marginalization of women in the broader field of hospital-based medicine was not a merely abstract reality of American medicine but was also concretely embodied in the constraints placed on women's participation in the work of its primary hospital affiliates.

The Presbyterian Hospital, which opened in 1872 and served as Columbia's principal teaching affiliate after 1911, had a gender-and-class conflict almost at its very foundation. According to Dr. Albert Lamb, Presbyterian's second historian and long-time associate:

On September 18, 1872, the Managers appointed Miss Jane Stuart Woolsey as Resident Directress of the Hospital. She was to have the general supervision of the Hospital plant and its routine, including nursing. There was also to be a Superintendent whose duties were concurrent, but it is clear that Miss Woolsey was his superior and acted in the same capacity as the Executive Vice-President does today. It also seems likely that the Managers created the position of Directress in order to secure her services, rather than that they created the position and then chose her from among several candidates. ...

At the time of her appointment she possessed an extraordinary record of experience. She was born in New York City in 1830 to a wealthy family and had received her education there. At the outbreak of the Civil War, she and her three sisters – Abby, Georgiana, and Eliza – devoted themselves to the Union cause. In 1861 they worked with the Woman's Central Association of Relief, the precursor of the United States Sanitary Commission and the American Red Cross. The four sisters were among the one hundred women selected for elementary training in nursing and for service at the City Hospital and the Park Barracks. In 1862 Miss Jane Woolsey served for five months at the Portsmouth Grove Government Hospital near Newport, Rhode Island, and then spent the remainder of the war at the Barrack Hospital in Fairfax, Virginia. The hostilities over, she helped organize and conduct the Freedman's Institute at Hampton, Virginia, under General Samuel Armstrong. She also opened the Lincoln Industrial School for Colored Women, another project of General Armstrong's.¹⁴

At that time Miss Woolsey's services were actively sought by several other institutions, including New York's Bellevue Hospital, which wanted to establish a training school for nurses. The newly opened Presbyterian, located on the hard-to-reach outskirts of the city, was very lucky to have won her over. Independently

¹⁴ Lamb, *The Presbyterian Hospital*, pp. 19-20.

wealthy, Miss Woolsey served Presbyterian without pay and her sister, Abby Howland Woolsey, joined her and assisted as clerk and occasionally as Acting Directress.¹⁵

According to Dr. Lamb, the early years of the Hospital saw some friction between its professional staff and administration and the root cause of the problem appeared to be that the Board of Managers had reserved to itself all administrative power. From time to time the disagreements between the professional staff and the Managers concerned appointments to the Medical Board, but the major conflict came to be centered around Miss Woolsey.¹⁶

Some of the younger doctors on the Medical Board opposed the appointment of a “lady superintendent” from the beginning. Miss Woolsey’s strenuous work during the Civil War had impaired her health, and organizing the Hospital’s routine made further demands upon it. Also, she was a woman of aristocratic background and temperament and was giving her services gratuitously. Accustomed to deference and respect, she found the hostility of some of the staff very disquieting. The matter came to a head when one of the doctors insisted on breaking a stringent rule by sending infectious cases to the wards. Miss Woolsey objected. The doctor and some of his colleagues then so opposed her that they were dropped by the Managers from the Medical Board. In turn, some of the other members of the Medical Board resigned, and so did some of the Managers. Miss Woolsey presented her resignation, but at the insistence of the Board of Managers withdrew it for the time being.¹⁷

Miss Woolsey stayed on for another year but then asked that her resignation be accepted. In Dr. Lamb’s words, “the upheaval had exhausted her, and she regarded her main task as done.” With sincere reluctance, the Managers accepted her resignation on March 1, 1876.¹⁸ Following her departure, a male superintendent of more modest social origins was appointed to assume her duties. The unfortunate

¹⁵ *Ibid.*, pp. 19-20. “Other administrative personnel included Miss Hester Rafferty as Head Nurse, the Matron (or Housekeeper), the Apothecary, the Curator, and the Engineer.”

¹⁶ *Ibid.*, pp. 22, 23.

¹⁷ *Ibid.*, p. 23.

¹⁸ *Ibid.*, p. 24.

consequences of this change were especially palpable, since he did not prove to be nearly her equal in the task of administering the Hospital.

Presbyterian's first historian – Dr. David Bryson Delavan – had witnessed the conflict personally as a young resident at the Hospital and concluded that the dispute of those first years “imperiled the existence of the institution and actually set back progress many years.”¹⁹ Dr. Lamb thought this judgment a bit too gloomy, but if the consequences of the larger process by which women were marginalized within the field of hospital and medical work were to be fully appreciated, Dr. Delavan's judgment would have to be found sounder and more insightful than he likely even realized. Insofar as Miss Woolsey's career exemplified a broader awakening of American women's ambition to participate in social and public affairs, her terminal replacement with a man was a sacrifice of those ambitions, as well as a sacrifice of aristocratic class solidarity for the sake of masculine unity among the social and professional elites. Miss Woolsey's expulsion was not an isolated event but a part of a broader rebuff to women's professional and social aspirations that would intensify and hold sway for close to a century. Following her departure, women's participation in the work of the Hospital was never again reach comparable position of power and authority.

Following Miss Woolsey's departure, the Hospital's organization and functioning assumed the typical gendered form, in which women were limited to separate, subordinate and marginal positions. The most crucial step in the institutionalization of the Hospital's gendered division of labor came with the establishment of its School for Nurses in 1892.²⁰ This decision by the Hospital

¹⁹ Quoted in Lamb, *The Presbyterian Hospital*, p. 26 from Dr. David Bryson Delavan, *Early Days of the Presbyterian Hospital*, p. 66.

²⁰ My sources on nursing: Eleanor Lee, *History of the School of Nursing of the Presbyterian Hospital, New York, 1892-1942* (New York: G. P. Putnam's Sons, 1942); Eleanor Lee, *Neighbors 1892-1967: A*

coincided with a larger movement on the part of the American hospitals to establish nursing schools. As the role of trained nurses in the provision of good hospital care rose in importance, hospitals struggled to attract and retain them in sufficient numbers. Graduate nurses were also more costly than the hospitals' traditional employees. Nursing schools provided hospitals with an abundant source of cheap labor. Pupil nurses could be immediately put to the many of the "custodial" nursing functions, while their supervision and the more advanced work could be carried out by a fewer number of paid graduate nurses.

During the first two decades of its existence, Presbyterian's nursing school established a pattern of training and employment characteristic of the "better" sort of nursing practice across the country. In its selection and training of nursing students, the School oriented itself toward an ideal that was simultaneously gendered and class- and race-specific. One of the primary goals of the Presbyterian nursing school was to attract the wholesome daughters of the [white] middle class to the profession.²¹ With its resources and prestige, Presbyterian largely succeeded in creating one of the country's best schools of nursing. It produced a large number of skillful practitioners and willful leaders who fought admirably for advancement and social recognition of nursing and women. Yet the overall effect of nursing and its professional struggles on the larger cause of women's equality in the professional and public spheres remains ambivalent.

History of the Department of Nursing, Faculty of Medicine, Columbia University, 1937-1967, and its predecessor the School of Nursing of the Presbyterian Hospital, New York, 1892-1942 (Columbia University-Presbyterian Hospital School of Nursing Alumnae Association, Inc., 1967); Gary Goldberg, *Nurses of a Different Stripe: A History of the Columbia University School of Nursing, 1892-1992* (New York: Columbia University School of Nursing, 1992).

²¹ For detailed discussion of racial minorities in the School of Nursing, see Goldberg, pp. 224-228. For a discussion of class dynamics in nursing's early history, see Charles Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (New York: Basic Books, 1987), especially Chapter 9, "Healing Hands: Nursing in the Hospital," and Chapter 4, "Expanding a Traditional Institution: Social Sources of Hospital Growth, 1850-1875."

By the last decade of the 19th century, when Presbyterian's School of Nursing was established, feminization of nursing was virtually complete. The profession's gendered identity was inscribed in the many practices surrounding nurses' training and practice, from uniforms to housing arrangements, curfew rules to relationship to physicians. Despite the clearly subordinate role of nurses in relation to physicians and hospital administrators, there was a specific sense of honor attached to nursing and especially to the leaders of the profession. Before closer affiliation with medical schools and widespread training of medical interns and residents, nurses were medical "professionals" and "apprentices" most closely and clearly associated with their respective hospitals. Trained nursing was considered one of the pillars of modern hospital care and the uniformed nurse corps was one of its proudest symbols. A photograph taken between 1910 and 1916 depicted a collegiate meeting of the Presbyterian's President, Superintendent and Director of the School of Nursing and was inscribed as "three great administrators of the old hospital."²² The honor, as well as the burdens, attached to nursing leaders partook of both monastic and military themes. Professional leadership presumed, both in theory and in practice, renunciation of marriage and family, while the strict discipline expected at all levels of nursing organization harked back to the founding institutions of Western modernity, including the monastery, the military, the penitentiary and the schools.

While women physicians were failing to win the right to be commissioned into the military service, the leaders of the nursing profession succeeded, albeit in a very difficult battle. The founder and director of Presbyterian's School of Nursing, Miss Anna C. Maxwell, was personally involved in winning the nurses military ranks and the nurses' service in the Spanish-American War and especially in World War I

²² Lamb, *The Presbyterian Hospital*, between pages 62 and 63.

brought an immeasurable degree of pride and confidence to the profession and women more broadly.

Yet, those who were fighting to elevate nursing and the nurses, had to sense that they were fighting the fight which was hard to win. The structural subordination of nursing to the medical profession had already been a foregone conclusion and the struggle only concerned the terms of this subordination, including the division of labor, conditions of employment, and material and symbolic rewards. As distinguished as the Presbyterian's School of Nursing was compared to the majority of American hospitals, the predominantly custodial nature of the nurses' training and the abiding paternalism in every aspect of nursing organization made it a questionable instrument in the cause women's equal participation in the medical field. Apart from symbolic gestures, even Miss Maxwell – Presbyterian nursing's founding and respected leader – was systematically excluded from the corridors of power and influence within the hospital. For the longest time, she did not even receive courtesy copies of the minutes of the medical board or the board of trustees and her administrative functions had been long as reduced to administration of the nursing service solely.

Like the nursing schools across the country, the Presbyterian's was from the very beginning subject to the seemingly never-ending debate on nurse over-training. By over-training, of course, the critics did not mean the inhumane hours and custodial content of the first-year nurses' hospital training, but the fear that the measly hours of actual classroom or bedside instructions in basic medical concepts and nursing techniques were so much of unnecessary and inassimilable science for the nurses' minds. After the affiliation with Columbia, this unfortunate debate morphed into the institutional tug of war between the Hospital and the medical school over the institutional place of the nursing school. The founding agreement between the two

institutions prescribed the transfer of all educational functions to the Schools and all the clinical services to the Hospital. The nursing school was the sole exception. The Hospital desired to retain full control over the disposition of its valuable resource of cheap hospital labor, while the University did not rush to embrace the feminized profession.

It is hard not to think that the occupational subordination of nursing and the constant belittlement of its professional and educational foundations, affected not only nursing but the cause of women in allied health care fields as well. More often than not, the discourses – both in favor and in opposition of thorough education of the nurses – were more than thinly colored by the gender of the nursing student. The issue of whether nurses should be instructed in this or that type of knowledge and technique often morphed into one of whether the feminine mind was fit to receive and apply them.²³

Ironically, during the early decades of the century, the nurses were far more visible than the female physicians fighting for professional success. Their sheer numbers, the spectacle of the uniforms, the honor of the war service all made the nurse the paragon of feminine patriotic duty. Enjoying high application rates, nursing was transformed – at the better schools at least – into a respectable collegiate major track for inspired young women. This, of course, created an odd sort of disjuncture in the purported class-determining effect of the educational opportunity, whereby the college-educated woman was routed into the profession that paid much less than that into which the college-educated man was. More ominously, the association of nursing with all-American femininity, and of femininity with nursing, was likely at odds with

²³ How much the presumed social class origins of the majority of nursing students had played into this questioning is unclear but an overdetermined juncture like this calls precisely for an acknowledgement that gender, as a category of social exclusion, is rarely without class and may even present a class structure all its own, overlain by racial and ethno-religious divisions as well.

the cause of women in medicine, a cause which threatened to upset the established gendered division of labor between the male physician and the female nurse.²⁴

The gendered precedents set at Columbia's other teaching affiliates – the Vanderbilt Clinic and the Sloane Hospital for Women – were of similar import. Both institutions, as well as the new home of the medical school, were gifts from the members of the wealthy Vanderbilt family and came about through the influence of Dr. James McLane, a family physician to the Vanderbilts and member of the College's faculty. The plot of land and the money for the construction of the new buildings to house the College were given by the patriarch of the family, William Henry Vanderbilt, in 1884. The Vanderbilt Clinic was given by his three sons in the memory of their father after his death. In 1886, Vanderbilt's daughter and son-in-law, Emily Thorn and William D. Sloane, offered to erect and endow on the College grounds "a lying-in asylum to be known as the Sloane Maternity Hospital of the College of Physicians and Surgeons."²⁵

The central role played by Emily Vanderbilt in this beneficence, as well as her lifelong financial support of this institution, served to cast into starker relief the gendered implications and practices of the Sloane Hospital under the control of College of Physicians and Surgeons. As most other institutions of this sort, Sloane Hospital was part of the larger institutional assault on the earlier practice of midwifery and its predominantly female ranks. The displacement of midwifery with obstetrics was both a class- and gender-specific project, replacing women of lower classes with

²⁴ This is just a supposition. While there are a number of excellent historiographies of women's role in both nursing and medicine, to the best of my knowledge, there had been no studies which systematically explore the relationship between the two. This is really regrettable because there is likely a strong link between the development of feminized occupations and the struggle for equal access to male-dominated fields.

²⁵ Harold Speert, *The Sloane Hospital Chronicle: A History of the Department of Obstetrics and Gynecology of the Columbia-Presbyterian Medical Center* (Philadelphia: F.A. Davis Company, 1963), p. 3.

men of middle- to upper-middle class status as principal attendants to the parturient. By virtue of the official exclusion of female students and physicians, the College of Physicians and Surgeons, under whose control the Sloane Hospital was placed, was doing its part. Until 1923, when the first female intern was appointed to Sloane, women's participation there was limited to financial beneficence, without corresponding control over institutional direction, and to nursing.²⁶ The situation was scarcely different in any other division of the School. The first woman physician appointed to the staff was Rosalie Slaughter Morton, who was made an attending surgeon in general surgery at the Vanderbilt Clinic in 1916.²⁷

During the first decades of its existence, the Sloane Hospital's nursing service and training school did not seem to have the fortune of the kind of success achieved at Presbyterian. The first several women appointed to head the nursing service left the institution within short periods of time, apparently without explanation. The Hospital's relationships with various nursing schools, which sent their students to take the obstetric rotation at Sloane, were often short-lived and strained. Finally, there were reports of overwork of nursing students which, in those times, indicated nearly unbearable conditions.²⁸

Besides nursing, which became nearly a sole domain of women's participation in the professional work of the hospital, the women's roles were in philanthropy, for

²⁶ As far as can be told, Emily Vanderbilt has never been appointed the Hospital's trustee. Her first husband, William Sloane, was a trustee. Both gendered and class processes were at work here. Female philanthropists were typically more constrained than their male counterparts in virtue of legal and cultural inequities concerning inheritance, property, and wealth-owning by women. Secondly, the power balance between the wealthy lay donors, including those who also served as trustees, and the medical profession was shifting in favor of the latter. The professional middle class – both in the guise of the doctor and the professional administrator – was establishing a much more insular base of power within the hospitals.

²⁷ Ellen S. More, *Restoring the Balance: Women Physicians and the Profession of Medicine, 1850-1995* (Cambridge, Mass.: Harvard University Press, 1999), p. 129.

²⁸ Speert, *The Sloane Hospital Chronicle*, pp. 130-141.

the very few who were in position to engage in it, and in the voluntary work of the hospitals' auxiliaries, which usually included the wives of the professional and administrative staff and other interested women, typically of upper-middle class standing.

On the national scene, however, the picture appeared to be brightening: just two years after Columbia ruled out the admission of women, another elite school, Johns Hopkins, agreed to admit women. Finally, it appeared that a long struggle for admission to the elite medical schools was finally brought to victory. The momentous decision, however, had less to do with enlightened views than financial exigencies. With the legacy left by Johns Hopkins, the Johns Hopkins University and Johns Hopkins Hospital had been founded, but decreases in the endowment and the cost of recruiting prominent faculty left insufficient funds to open the medical school. Elizabeth Garrett and several friends had offered financial support if women were admitted. The funding secured was still insufficient and the Trustees had decided that nothing less than a first-class medical school was acceptable and they would wait until sufficient funds were available. Finally, Elizabeth Garrett offered to donate \$500,000, the entire amount needed to open the medical school, if women were admitted and four years of undergraduate preparation were required for admission. Despite concern that students would not attend because of the strenuous admission requirements and the presence of women, the Trustees had no other choice and accepted. Three women were admitted to the first year class out of the total of twelve students. A few years later, the famous William Osler apparently declared that the experiment of admitting women was a failure but the "die was cast."²⁹ In effect, as Paul Starr commented, "American women were forced to buy their way into elite medical education."³⁰

²⁹ Quoted in Gerard N. Burrow and Nora L. Burgess, "The Evolution of Women as Physicians and Surgeons," *Annals of Thoracic Surgery* 71 (2001):S27-S29. Also see Mary Roth Walsh, "Doctors

After the medical schools of Johns Hopkins and Cornell began admitting women in 1893 and 1898, respectively, the New York Infirmary and other women's medical colleges closed; the reasoning was that there was no need for separate education for women doctors. Little did they know that it would take two more decades before Columbia University College of Physicians and Surgeons would start admitting women. The last citadel, Harvard Medical School, did not accept female students until 1946.

By the beginning of the 20th century, a number of medical schools were admitting women, although most of these were homeopathic or proprietary schools of a second or even a third rank. The general opposition – both on the part of the medical profession at large and of the most established medical schools in particular – persisted and even intensified in the climate of growing competition for institutional survival. As one of the results of the process of upgrading and standardization of medical education, which culminated in a famous Flexner's report of 1910, a large number of those schools which admitted women disappeared during the first decade of the 20th century. By 1909 only three women's medical colleges still existed. The number of female medical students has plummeted as well. Between 1904 and 1909, the number of women medical students nationwide had decreased from 1,129 to 921. The decline was not due to the disappearance of women's schools only, as at the coeducational institutions the number of women students dropped from 752 in 1910 to 464 six years later.³¹ For the next half century after 1910, except the wartime, the

Wanted: No Women Need Apply: Sexual Barriers in the Medical Profession, 1835-1975 (New Haven, CT: Yale University Press, 1977).

³⁰ Starr, *The Social Transformation of American Medicine*, p. 117.

³¹ *Ibid.*, p. 124.

schools maintained quotas limiting women to less than 10 percent of medical student admissions.³²

The overall situation of (white) women's medical education during the late nineteenth and early twentieth century is usually characterized as one of gender separatism and marginalization, but it should also and importantly be comprehended in terms of class. The unenthusiastic admission of women by less prestigious, cash-strapped institutions forced even the best-bred young women foolhardy enough to insist on medical vocation to receive their degrees from second- or third-rate institutions. The lack of financial resources and widespread ostracism relegated all-women's colleges of medicine to similar rank within the hierarchy of medical schools. Perhaps even more damning than the imputed worth of women's medical degrees were their limited professional opportunities after graduation. In the majority of cases, the combined ostracism of professional societies, local practitioners, hospitals, and the public limited women's practices to far less lucrative and prestigious types of practice among the poorer clientele, especially women and children; with charitable clinics for the poor, the tubercular, and the confined; and in the less competitive geographic areas of smaller cities and towns. With few exceptions, women's practices were far less conducive to advancement of medical technique and, for a long time, they were categorically barred from the participation in the professional societies and their scientific meetings. Thus, even the beginning of women's admission at the few top-ranked schools did not dramatically change the de-classing processes forced upon the pioneering generation of American women physicians. Even a hard-won degree from

³² Similar fate befell Black medical colleges, as well as those less prominent schools which during the end of the nineteenth century offered admission to the ambitious sons and daughters from the working class and immigrant families. Schools in smaller and poorer communities were also closing, unable to secure certification and to compete with better schools. Thus, the flowering of the process of professionalization of American medicine at the turn of the century established a system of barriers based in gender, race, class, as well as in ethno-religious and national status.

a prestigious institution could not by itself compensate for the enormously constrained professional opportunities imposed by the multiple refusals of hospitals, male colleagues, and paying patients to help the women to appointments, training, partnerships, referrals, and earnings.

It is true that those women, who could rely on family or marital wealth, were in many cases able to build financially successful private practices in the metropolitan centers, but theirs were exceptional, rather than typical outcomes. Overall, even as the arduous task of overcoming multiple obstacles to medical profession ensured that only the most hard-willed daughters of middle- and upper-classes would ever venture into the field, the regime of their marginalization had the effect of de-classing their professional and personal situation in relation to their male peers. The combined effects of less prestigious degrees, limited career opportunities, lower-class clientele, and professional exclusion, made career in medicine an exercise in hardships, iniquities and sacrifices which these pioneering women bore with amazing dignity and resolve.

A quarter of a century after Columbia's first official position on the admission of women, the question was being raised once again and, this time, it was decided differently. This is how the College's Alumni Newsletter described the momentous event in the issue honoring the 75th anniversary of women's admission.

Back in 1917, when Gulli Lindh '21 (later married name Muller) sought entry to the then all-male College of Physicians and Surgeons, Dean Samuel Lambert stipulated that if \$50,000 could be found for the necessary improvements of the physical plant, i.e. separate washroom facilities, he might consider her application. It was a stalling tactic akin to those impossible chores with which the hero or heroine is charged in fairy tales. True to the world of once upon a time, a fairy godmother (or rather father) interceded on her behalf: an anonymous Texas gentleman (whose two sisters were doctors)

came through with a gift of \$50,000. And so 9 young women, including Gulli Lindh, were subsequently admitted to the Class of 1921.”³³

Instead of comparing this curious event to the fairy tale, it may be fairer to say that Columbia had followed in the footsteps of Johns Hopkins and several other elite schools in allowing women and their supporters to “buy” their right to admission. The price of admission to Columbia was certainly not as high as it was at Hopkins and bespoke lesser resistance to this step. Why and how this change of heart had taken place is unclear, nor is the full spectrum of opinion on the matter which undoubtedly existed. The power of the precedent, however, was probably one of the factors. By 1916, when Gulli Lindt and her future classmates sent their applications, several of the top medical schools have already allowed the admission of women: Johns Hopkins did so in 1893, Cornell in 1898, and in 1915 Yale joined in as well. The approach chosen also had a virtue of being open to several interpretations – as either a stalling tactic or a pragmatic financial decision – suitable to the divided opinion of the faculty.

Four years later, the results of this experiment, as the decision to admit women was to be referred for a long time, were in and the rumors spreading through the University were that they were quite impressive. In a brief note to the Dean of the medical school, Columbia’s President, Dr. Nicholas Murray Butler, wrote:

It occurs to me that in view of the excellent record made by some of the women students in the first class to be graduated at the P. and S. that contains women, it would be well to make public from the University some facts relative to the matter. We should not want to mention names of the individuals.³⁴

The President asked the Dean to furnish him with some facts to use as the basis for “a little public statement.” For instance, the President wanted to know the number

³³ One page copy from (?) P&S Alumni Newsletter, undated, probably 1992.

³⁴ Nicholas Murray Butler, LL.D., President, Columbia University to William Darrach, Dean, College of Physicians and Surgeons, February 12, 1921.

of women admitted to the graduating class, colleges from which they came, their general record at the P. and S. as a group, and the hospitals to which these women are securing appointments. He was particularly impressed to hear that “women stood first, third and fifth in a class” and wanted to have this fact confirmed, as well as Dean’s comments on the “significance of this for the development of women’s part in medicine” or “anything else that you think would be useful to the P. and S. and the general movement in this connection.”³⁵

With less enthusiasm, perhaps, the Dean provided the following report. A total of twelve women were admitted to the Class of 1921 but only 6 of them graduated. Those who did graduate held the following ranks among the 117 graduates: 1st, 3rd, 5th, 46th, 49th, and 60th.³⁶

The following information was available about the six women who did not graduate:

- 1 dropped after 2 months as her preliminary education was insufficient (misrepresentation)
- 2 dropped in February of 1st year, no reason stated
- 1 at the end of 1st year because of 2 failures and 3 C’s
- 1 was dropped at the end of 2nd year after receiving one condition in her 1st year
- 1 withdrew at the end of 3rd year to be married; had 13 A’s and 3 B’s in first 2 years]³⁷

It is of interest, wrote the Dean, that “[a]ll the women have medical hospital appointments, rather than surgical.” His only other comment was that “[o]ne striking thing [about the first women medical students] has been their attitude towards special privileges; they have not only not asked for it but refused to accept it when it was

³⁵ *Ibid.*

³⁶ William Darrach, Dean, College of Physicians and Surgeons to Nicholas Murray Butler, LL.D., President, Columbia University, February 12, 1921.

³⁷ *Ibid.*

offered.”³⁸ Thanking the Dean for his report, Columbia’s President noted that the women’s record “show[ed] that a very interesting experiment has produced good results in its beginning at any rate.”³⁹

Although the experience of the first co-educational class may have been expected to exert some influence on the future policy on the admission of women, it has instead set in stone the institutional attitude which would scarcely change in the next five decades. The main elements of this static regime of gender policy were: (1) the consistently better academic results of female students compared to that of male; (2) intermittent institutional pride about these results often worked into the public relations opportunities; (3) refusal to increase the rate of women’s admission in light of their better academic performance; (4) mainstreaming of women into medical, rather surgical internships; (5) contentment with not having to adjust any institutional practices on the account of women students.

Undoubtedly, there were a number of individuals among Columbia’s faculty and administration who strongly supported the broadening of women’s opportunities to study medicine. Yet, an amazing finding was that during the next twenty years the average proportion of women in the graduating class remained exactly the same as it was in the first class that included women. One of the individuals who worked toward breaking this quota was Prof. Florence Lowther of the Department of Zoology at Barnard College. In 1943, she collected and analyzed the records of the first twenty years’ of women at the College of Physicians and Surgeons and forwarded her findings to the Dean of the Medical School.⁴⁰

³⁸ *Ibid.*

³⁹ Nicholas Murray Butler, LL.D., President, Columbia University to William Darrach, Dean, College of Physicians and Surgeons, February 18, 1921.

⁴⁰ Copy of Prof. Florence deL. Lowther, Department of Zoology, Barnard College, Columbia University (with Dr. Helen Downes ?), “Statistical Report on the Women Doctors Who Have Graduated from the

According to Prof. Lowther's study, the basic numbers on women graduates were as shown in Table 5.1. According to the study, 31 percent of women graduated with honors while only 13 percent of men did. Although women accounted for only 9 percent of all graduates, they held 18 percent of honor ranks.⁴¹ 85 percent of women graduates of the College of Physicians and Surgeons were practicing while 15 percent were listed as "not in practice" at the present moment in the 1942 Edition of the American Medical Association Directory.⁴² In her cover letter, Prof. Lowther noted that "[a]ccording to your [P&S] records in the Registrar's office, many of these [15 percent currently 'not in practice'] have practiced for from five to eighteen years." Hence, she intended to "make further inquiry into the reasons for their present inactivity." The proportion of women graduates in active practice was calculated on a sample of 162 persons. 13 of 175 graduates were either deceased or could not be found. 52 women graduates, or 32 percent, were either full or partial specialists and 21 percent of women graduates were full specialists. The leading specialty practice among women graduates was pediatrics (26 percent of full specialists and 33 percent of full and partial specialists); dermatology (14 and 10 percent); pathology and psychiatry (11 and 8 percent each); gynecology and surgery (6 and 8 percent).⁴³

College of Physicians and Surgeons," enclosed with a cover letter to Aura E. Severinghouse, Assistant Dean, February 19, 1943.

⁴¹ *Ibid.*, Table I, "Honor Rank of Student in Each Class (1st through 15th)" and Table III, "Scholarship of Women Students Compared (sic) With Men." If we look at top 10 ranks, rather than top 15, the results are even more impressive. Of 200 spots in Top 10 over twenty years, women held 42, or 21 percent, while representing only 9 percent of all students. Over the same period, women graduated first in their class 5 times, or 25 percent of the time. These are my recalculations of Lowther's data in Table I.

⁴² *Ibid.*, Table IV, "Proportion of Women in Active Practice."

⁴³ *Ibid.*, Table V, "Types of Practice." It is unclear on whose initiative the study was undertaken and with what purpose. In her cover letter, Lowther thanks Assistant Dean Severinghaus for his "cooperation in this first effort" and praises the College's Registrar for her "prodigious and accurate memory." She also thanks Severinghaus for sending her some articles on women in medicine and tells him that Dr. Helen Downes and she intended to expand their study to "at least five more medical colleges." Thus, some official sanction or, at least, knowledge of the study appears possible. For his part, Dr. Severinghaus thanked Lowther for "the extremely interesting data" and admitted being himself "somewhat surprised" at her findings. (Severinghaus to Lowther, February 22, 1943.)

Table 5.1. *Women Graduates of the Columbia University's College of Physicians and Surgeons, 1921-1941*

Class	Year of admission	Total number of graduates	Number of women graduates	Percent of women graduates
1921	1917	70	6	9%
1922	1918	70	7	10%
1923	1919	94	12	13%
1924	1920	88	10	11%
1925	1921	94	11	12%
1926	1922	105	11	10%
1927	1923	96	11	11%
1928	1924	97	11	11%
1929	1925	103	14	14%
1930	1926	103	5	5%
1931	1927	102	9	9%
1932	1928	102	7	7%
1933	1929	91	6	7%
1934	1930	98	5	5%
1935	1931	97	6	6%
1936	1932	88	11	13%
1937	1933	93	7	8%
1938	1934	91	6	7%
1939	1935	88	7	8%
1940	1936	103	10	10%
1941	1937	104	3	3%
TOTAL		1,977	175	9%

Source: Prof. Florence deL. Lowther, Department of Zoology, Barnard College, Columbia University (with Dr. Helen Downes ?), "Statistical Report on the Women Doctors Who Have Graduated from the College of Physicians and Surgeons," enclosed with a cover letter to Aura E. Severinghouse, Assistant Dean, February 19, 1943, Table II, *Proportion of Women in Each Class*. *Notes:* Columns I, II, and IV are from Lowther's Table. Columns II and V, giving year of admission and percentage of women graduates respectively, have been added by me (O.P.). My calculation of the total number of P&S graduates between 1921 and 1941 gives the result of 1,977, while Lowther had 1,967 which I believe is a typographical error. Also, on the basis of her numbers, Lowther reported the average proportion of women graduates to be 8 percent, whereas 175 divided by 1,967 is actually 8.89 percent, i.e. almost 9 percent.

"It seems to me," wrote Lowther, "that their records as students are nothing short of superb." More importantly, "their subsequent career as medical practitioners

should put to rout (sic) those who claim women doctors doe (sic) little with their knowledge after graduation.”⁴⁴ “I am myself somewhat surprised by your findings,” wrote Assistant Dean Severinghaus, thanking Dr. Lowther for the study and “the extremely interesting data that it contained.”⁴⁵

Did this study prompt any changes in admissions policy on the part of the P&S? The answer appears to be no. The only divergence during this period occurred immediately after World War II. It could have been expected that the wartime shortage of qualified young men would result in the increase of the proportion of women admitted but that did not really happen at Columbia. The policy behind the unchanged numbers was confirmed by the Dean of the Medical School. Replying to an inquiry regarding any changes in the number of female students “in response to war pressure” and whether P&S was “offering them any inducements or discouraging them,” Dean Rappleye said only that, at P&S, “[they were] continuing to take the same number of women ... as previously and [were] very glad to do whatever we can to help them with their training.”⁴⁶ It was not the war shortage of men, but the glut of returning veterans and the federal provisions for them, which were responsible for the one and only spike in the proportion of women graduates during this time. In 1945, 25 women were admitted to the Class of 1949 and four years later 23 women graduated in a total class of 108. Accounting for 21 percent of all graduates in 1949, this was a departure from the average proportion of 9 percent. The departure was widely noticed and this is how the unusual graduation ceremony of that year was described in the news.

⁴⁴ Prof. Florence deL. Lowther, Department of Zoology, Barnard College, Columbia University to Aura E. Severinghaus, Assistant Dean, P&S, February 19, 1943.

⁴⁵ Aura E. Severinghaus, Assistant Dean, P&S to Prof. Florence deL. Lowther, Department of Zoology, Barnard College, Columbia University, February 22, 1943.

⁴⁶ Maude Glasgow, M.D., DrPH, New York, NY to Dean Rappleye, January 3, 1944; Rappleye to Glasgow, January 6, 1944.

Women in medicine took a giant step forward this week. For the first time in history of Columbia's august College of P and S, 23 of 108 graduates were women. The ladies usually number only six or eight. A young mother, Mrs. Anthony Ianone, walked off with one of the two highly coveted surgical internships at Columbia's PH. Six out 18, exactly one third of the students tapped here for Alpha Omega Alpha, national honor society were women. To make the feminine victory really complete, by graduation time five of the girls already were married to fellow students. And from rumors circulating about the campus, more will be following their example soon. Wartime absence of qualified young men four years ago was partly responsible for the large feminine percentage. But the chief reason for their astounding number, according to Dr. Aura Severinghaus, a dean of the medical school, was the plain fact that "so many excellent young women applied at that time." They had the makings of good doctors, he said. And like men in the profession planned to continue their careers after marriage. Of the lady graduates from P. and S. Interviewed, not one had noticed the slightest prejudice against them in their entire four years. "In fact, the older doctors, the men least likely to accept the idea of women in medicine, bent over backward to be kind," observed lovely, dark-haired Roxana Read, who is taking a rotating internship in Texas. "I wasn't aware that there was such a thing as prejudice at all until I filed an application by mistake at a hospital which did not accept women. Fortunately, there aren't many like that." The married girls are just as convinced they'll stick to their careers as the single. Commented Mrs. Yvonne Wyker, who is planning to intern at Rochester with her husband, "Better to try both marriage and medicine than give up one for another, although we all know we are up against serious hazards." "Just looking around at the successful women at Columbia was always encouraging to us," Roxana Read added. "Dr. Virginia Apgar, anaesthesia, Dr. Barbara Stimson, fractures, Dr. Edith Quimby, radiology. I was Howard Schnur, veteran of the ETO and fellow graduate, who delivered the greatest accolade. "The girls were always hard working lab partners and knew most of the answers. They could have been intolerable if they wanted to but they weren't. Why, I dated one girl for the years and she never mentioned medicine once outside school."⁴⁷

The feminine victory, however, was rather short-lived and its true reasons were other than those stated for the record. Recalling the wartime experience, P&S alumnus and current administrator was more candid:

⁴⁷ Columbia's Girl Meds Score Slam," *New York World Telegram*, June 3, 1949, all paragraphing removed.

It was an unusual class after the war. We had about 15% women and after that it dropped back to the usual 8%. We were told that the reason was that P&S would rather take women than be assigned these people from the army and navy.”⁴⁸

The surprising absence of gender discrimination, described in the newspaper article, was also probably an exaggeration. As another alumna of the College reminisced in an article devoted to women in medicine, some professors still bristled with hatred toward the female students and the institutional practices hardly proscribed their open expression of this sentiment.

In 1947, I was accepted by Harvard Medical School but elected to go to P&S. In September of that year, at a welcome reception for the entering class of '51, a senior faculty member pointed to me: “Had I been on the admissions committee you would have never been accepted.” In the midst of general hilarity I treated it as a joke and chuckled, “And why not?” He said, “Because women get married, have children and waste their education. Don’t you laugh, young lady, I am serious.” This was my introduction to P&S. I could have told him that I was already married, but I didn’t want to spoil his fun. I am very lucky that he was not on the admissions committee.”⁴⁹

Reflecting on the consequent return of the women’s percentage to its average levels, Dean Rappley wrote that “[e]ach year since 1917 approximately ten per cent of the medical students have been women. During the war period the percentage rose to above thirty but only for a short time because immediately following the war the number of women applicants dropped markedly.”⁵⁰

To the credit of some of Columbia’s leaders, the institution did not hesitate to share its data on the excellent academic accomplishment of the women graduates.

⁴⁸ “The Double Image: Women and Minority Students at P&S,” report prepared by Nancy A. Anderson, ’80 and Mary J. Roman, ’80, presented to Dr. Bernard D. Challenor, Associate Dean and Dr. Bernard Schoenberg, Associate Dean, October 1977, pp. 40-41.

⁴⁹ Lila Wallis, “Women in Medicine: Struggles and Contributions” in *Fathom: The Source for Online Learning* (Fathom Knowledge Network, 2002, on the web at <http://www.fathom.com/feature/35351/>).

⁵⁰ Willard C. Rappleye, Dean, to Miss Bessie Grigg, Managing Editor, *Medical Woman’s Journal*, Newport, Kentucky, February 20, 1950.

When, five years after Harvard decided to admit women, the school's leaders were still quite unsure of the correctness of their decision, Columbia's data was likely sought as ammunition. The Chairman of the Harvard Medical School's Committee on Admission wrote to the Dean of Columbia's medical school, Dr. Severinghaus, for advice in this matter:

The question of advisability of admitting female medical students in the present rush of candidates is rearing its ugly head among the faculty once more at Harvard. Our experience with this sex as graduates is too brief to be of statistical value. I wonder if you have any statistics as to the number of women medical graduates who are still actively engaged in medical work five or more years after their graduation. Such statistics would be most helpful to us in the discussion of this problem which is bound to come up.⁵¹

In his reply, Dean Severinghaus replied that the "experience at the College of Physicians and Surgeons has been very satisfactory indeed and we would have no reason at all to question the desirability of continuing their admission." To support his view, he cited the main findings of Dr. Lowther's study of P&S women graduates between 1921 and 1941.

Over a twenty-year period, from 1921 to 1941, we have graduated 175 women, 13 of these died. Of the remaining 162, 85% were still practicing actively and 15% were not practicing at the present moment. We understand that a considerable number of this 15% again took up active practice during the emergency years of World War II. It also interested me to know that 32% of this number had gone on for specialty boards and that 60% were in general practice. Their achievement in medical school was outstanding. 8% of the total number of graduates were women, although 18% of the total honor ranks were captured by them. 31% of the 175 women graduated with honors, that is, within the upper fifteen places in the class, whereas only 13% of the men graduated with honors. Thus our record both within school and after school compare very favorably with those of the men and I believe we have no

⁵¹ Dr. Kendall Emerson, Jr., Executive Chairman, Committee on Admission, Harvard Medical School to Aura E. Severinghouse, Associate Dean, April 12, 1951.

hesitation at all in continuing the admission of women to the study of medicine.⁵²

Still, the institution as a whole did not deviate from its established percentage of female admission until compelled by the wave of civil rights and feminist struggles of the 1970s.

The most interesting aspect of these decades' regime of gender discrimination was that, on the surface, no discrimination was taking place at all, in the practice of admissions at least. Women were consistently admitted to medical schools at the same rate as men were. When they applied in greater numbers, as it happened right after the war, their proportion among the admitted students rose correspondingly. In view of their better academic performance, which was well documented at Columbia, it is possible to make a charge that Columbia should have increased the rate of admission, given the clearly superior pool of applicants which women represented. This charge, to be sure, could have been easily countered by the likewise documented short-fall which the women graduates were showing in the post-graduate professional performance. The bulk of the critical assessment, I believe, has to be laid elsewhere: on the fact that most institutions are capable of influencing their application pools and numbers. To be sure, they are not the only factor in this, but they are able to communicate their intentions quickly and clearly to the colleges from which their applicants are predominantly drawn.

Unfortunately, there must have been absent a sufficient support within the Columbia's establishment to raise the percentage of women beyond the average of under ten. Given that this number slightly exceeded the national average, the actions of Columbia's medical school were innocent of open discrimination, yet eerily

⁵² Severinghaus to Kendall, April 18, 1951. Dean Severinghaus failed to acknowledge Dr. Lowther's authorship of the study saying instead that: "last June I prepared a talk on the progress of our women graduates during the last twenty years, so I have some data which may be of interest to you."

calculated to keep the proportion of women in medicine an inconsequential minority. As the sociologist Rosabeth Moss Kanter has shown in her pioneering study of minorities in the workforce, there exist certain significant thresholds which determine minority's power potential. Minorities, whose numbers fall below 15 percent, are rarely able to influence the decision-making and policies of their institutions, functioning more as tokens than full-fledged participants in their fields. Minorities constituting between 15 and 30 percent, however, are usually able to make alliances with their majority supporters and advance their positions in this way.⁵³

The broader significance of women's quotas – at Columbia and nationwide – was that women in medicine could not build effective campaigns to increase their numbers. Quite unlike the happy normality depicted in the newspaper account of the post-war crop of women M.D.'s, exceptionalism, isolation and quietism were the primary effects of this regime on women in medicine.

During this period, both professional and organizational weakness of women in medicine worked to inhibit the growth in applicants to medical schools and the struggle against the unjust conditions of their participation in the profession. The experiences of Columbia's women graduates differed significantly from the earlier generations of women. They entered the profession at the moment when women physicians had mostly lost the earlier gender-specific niche which helped increase and support the earlier generation of women physicians. As historian Ellen More concluded:

The devaluation of a gendered conception of women's practice and the elimination of the professional outposts from which earlier generations of women physicians had made their mark disrupted patterns of recruitment and advancement from women physicians. Previously women physicians, and not

⁵³ Rosabeth Moss Kanter, "Some Effects of Proportions on Group Life: Skewed Sex Ratios and Responses to Token Women," *American Journal of Sociology* 82 (1977): 965-990.

merely those who taught at women's medical colleges, had attracted professional successors through networks of personal and professional reputation. By the 1920s they could claim few heirs, not only because women's admissions to medical school were low but also because, in a world where internships, residencies, and hospital privileges replaced gender-specific medical institutions as avenues to professional prestige, senior women physicians were rarely able to help young women colleagues up the career ladder.⁵⁴

Even successful women practitioners were deflected from full participation in hospitals, which increasingly constituted a critical factor in the advancement of medical careers. Women's under-representation on most hospital inpatient staffs, as well as in internships and residency programs, significantly slowed their move into the core institutions of twentieth-century medicine – hospitals, medical specialties, and medical school faculties.⁵⁵

Women's organizational politics were also in disarray. The national women's medical organization attracted limited membership and its greatest accomplishment – both domestically and overseas through the American women's hospitals – represented a clearly gender-specific and marginalized achievement, focused on the service to the needy, especially women and children, and on public health and preventive medicine abroad. An organization that began as an exercise in demonstrating women's equal professional competence ended up operating within women physicians' traditional, culturally sanctioned role that, alas, remained professionally marginal.⁵⁶

Passage of the 1921 Act for the Promotion of the Welfare and Hygiene of Maternity and Infancy, better known as the Sheppard-Towner Act, one year after the ratification of the woman suffrage amendment, seemed to presage a breakthrough for

⁵⁴ More, *Restoring the Balance*, pp. 120-121.

⁵⁵ *Ibid.*, p. 96.

⁵⁶ *Ibid.*, pp. 123-125 and 147.

maternalist medicine and for women physicians. But the moment was short-lived. In 1929, under the pressure of conservative backlash and anti-communist hysteria, the act and the agencies created under its authorization, including the Children's Bureau, were allowed by the Congress to expire.⁵⁷

With repeated defeats, adaptive professionalism, not feminism, was ascendant among women physicians.⁵⁸ The MWA's was careful to oppose compulsory health insurance and socialization of medicine in general. It refused to admit African American women physicians to its organization until 1942. The Association also opposed birth control and abortion as a matter of policy and reduced the problems of women in medicine to the difficulties in securing household help.

If women remained a small minority in medicine as whole, they were even more exceptional in the academic medicine. In spite of steady erosion of the women's institutional niches, the few successful women in academic medicine were located predominantly in pediatrics and a few fields closely associated with it. Women who gained prominence in academic medicine were generally exceptional – in their backgrounds, talents, lifestyle, and luck – which did not bode well for increases in their numbers. In her analysis of seven outstanding women academicians before 1950, Ellen More concluded that they had several characteristics in common.

Generally speaking, they all received substantial boosts early enough in the career to propel them beyond the lower academic ranks. But in addition, they consistently performed at high or even “super achiever” levels. (f73) All were educated at excellent coeducational medical schools. They were admitted to high-quality internships and residencies and continued in academic medicine directly after finishing their training. Much of their forward momentum was a result of their own gifts and preparation, of course, but it also resulted from astute and committed mentoring by male faculty who recognized their skills and went out of their way to alert them to career opportunities. Frequently

⁵⁷ *Ibid.*, p. 148.

⁵⁸ *Ibid.*, p. 149.

they created and became identified with innovative clinical approaches, sometimes working at the border of clinical specialties. ... Several attained the rank of full professor, although none became a dean, department chair, or hospital administrator.⁵⁹

Besides outstanding abilities and mentors, these women's careers were marked by exceptional personal choices or sacrifices which set them apart from the vast majority of women. It is hard to escape the conclusion that the career success for these women was strongly associated with foregoing of the traditional family life. Five out of seven in More's group never married or had children of their own, although two of them shared a household with each other.

The career of Virginia Apgar, a graduate and a faculty member of Columbia's College of Physicians and Surgeons in many ways typified the few women who managed to enter academic medicine during the middle-third of the twentieth century.⁶⁰ Apgar was born in 1909 in Westfield, New Jersey, to a middle class family. Her father's active interest in science and experiments, combined with a death of an older brother and a chronic illness of a younger one, were the likely sources of Virginia's interest in a medical career. Apgar attended Mt. Holyoke College, drawing financial support from scholarships and a variety of jobs, including catching stray cats for dissection in the zoology laboratory. In September 1929, she entered the College of Physicians and Surgeons at Columbia University. The onset of the Great Depression has considerably complicated Apgar's financial situation and, despite the availability of small scholarships, she had to borrow money from family friends. She graduated in 1933, fourth in her class and nearly \$4,000 in debt.

⁵⁹ *Ibid.*, p. 171.

⁶⁰ I have relied primarily on an excellent biographical account and historical analysis of Apgar's career by Selma Harrison Calmes, "Virginia Apgar: A Woman Physician's Career in a Developing Specialty," *Journal of the American Medical Women's Association* 1984, Vol. 39, No. 6, pp. 184-188. Calmes' article is based on her research of the Apgar Papers collection at the Mount Holyoke College Library Archives and on personal interviews with Apgar's associates.

During her last year, Apgar won a prestigious and – for a woman – a rare opportunity to become a surgical intern at Columbia-Presbyterian. Although she performed brilliantly at this task, Columbia's chairman of surgery, Dr. Alan Whipple, discouraged her from continuing in the field of surgery. Instead, he suggested that Apgar choose anesthesia as her field of specialization. Whipple had at least two reasons for deterring her. He had trained four other women surgeons and they had not been financially successful. Surgery was a crowded specialty in New York City and it was the Depression: even men had trouble getting established. Apgar, of course, had to support herself, since her family was not wealthy and she was not married.

Another reason Whipple urged her not to continue in surgery was his recognition of the need for better anesthesia. At that time, few physicians specialized in the field, and most anesthetics were given by nurse anesthetists. As many others, Whipple realized that surgery could not advance unless anesthesia did. It is likely that he saw in Apgar the energy and ability to make significant contributions to this area.

Although this is not documented, Whipple may also have urged Apgar to enter anesthesia because it was then thought to be a suitable field for a woman and one in which there would be considerably less competition from men. When Apgar graduated from medical school, anesthesia has not yet been widely recognized as a separate medical specialty. Even if some leading academic surgeons recognized the need to develop anesthesia as a separate specialty with research agenda, because of low prestige and low pay, it was difficult to interest male physicians in this area. Thus, women doctors and nurses comprised a disproportionately large number of personnel who specialized in performing anesthesia. From 1920 to 1948, women comprised 11-13 percent of professional anesthesia organizations but only 3-4 percent

of physicians at large. There were even three female presidents of national anesthesia societies between 1922 and 1930.⁶¹

Less than a year after starting her surgical internship, Apgar began looking for training in the new field. At first, she stayed at Columbia-Presbyterian, probably for financial reasons, and spent almost a year training with nurse anesthetists. After that she trained for six months each with Ralph M. Waters, M.D. at the University of Wisconsin and then with his protégé, Dr. Emery A. Rovenstine, at Bellevue Hospital in New York. Both in Wisconsin and at Bellevue, Apgar faced the all-too-common problem confronted by the women of her generation, that of the lack of housing facilities. In Madison, she moved three times in six months, while at Bellevue, she ended up living in the maids' quarters. It is then that, for the first time, she recorded in her diary her feelings of frustration at her exclusion on the account of her gender. "Fairly good meeting," she wrote, "but stag dinner-MAD!"⁶²

Five years after her graduation, Apgar was invited to return to Columbia as "Director of the Division of Anesthesia and Attending Anesthetist." Beneath the impressive title, however, lay a rather compromised and constrained position. Almost immediately, Apgar encountered tremendous difficulties on four fronts: limited recruitment, an overwhelming clinical load, reluctance by the surgeons to accept anesthesiologists as their equals in the operating room, and difficulty getting adequate compensation.

Recruitment was difficult because administering anesthesia was still thought of as a nurse's job. Apgar was the only staff member until August 1940, when Dr. Ellen Foot, one of the residents, joined her. The situation did not improve much until after the war when many of the physicians returning from World War II showed increased

⁶¹ All statistics from Calmes.

⁶² Quoted in Calmes, footnote 10.

interest in anesthesia. 1945 was the first year in which more anesthetics were given by doctors than nurses. The number of nurse anesthetists decreased sharply during this period and, gradually, they were replaced by the growing number of medical interns. The success of anesthesiology as a medical specialty, thus, came at the expense of the professional advancement of nursing and nurses. Ironically, the process which allowed some of the women physicians to carve out their careers was also depriving the nursing, still by far the largest female profession in health care, of an established area of professional specialization.

Another problem which Apgar's lofty title disguised was the surgeons' refusal to accept anesthesiologists as their equals in the operating room. Having administered anesthesia themselves or with the help of surgical nurses for years, surgeons often thought they knew what was best for the patient, even though the methods and techniques were changing rapidly. They were also accustomed to giving orders to and receiving compliance from the nurse anesthetists.

Finally, there was the problem of adequate financial compensation. Physicians giving anesthesia were not allowed to charge professional fees. In October 1940, Apgar threatened to resign because of inadequate compensation and inability to charge fees, and followed through in December. Although not documented, this conflict was apparently resolved, because she did return. The anesthesia division was funded by charges for operating room use until 1941 when a budget was allowed. Private and semiprivate patients were to be billed for anesthesia at the discretion of the surgeon, placing the anesthesiologist into direct dependence upon the surgeon. Being able to charge a fee is the ultimate symbol of a professional and this situation clearly indicated that the anesthesiology was still a subordinate field. Both its erstwhile status

as a nurses' function and its considerable feminization were likely responsible for this situation.⁶³

Different problems faced Apgar after the war. As anesthesia was gaining increased recognition as a medical specialty and the interest among students increasing, Apgar thought it was time to form a physician-only department, to separate from surgery, and to develop a strong research program. Apparently reasonable proposals, they have nevertheless met with considerable opposition and for the next three years Apgar was forced to engage in a difficult struggle over the department's structure and the role of research. Evidence indicates that Apgar expected to be made chair. But in 1949, Emmanuel Papper, a Bellevue anesthesiologist with a research background, was made head of the division. It became a department six months later. Apgar and Papper were both appointed professor, making her the first woman full professor at Columbia.

Sidelined from chairmanship of the department she helped create, Apgar moved into a new field of obstetric anesthesia where she was able to make her greatest contribution. Her most important innovation was the Apgar Score, a standard evaluation procedure of the newborn child. First published in 1953, it became and remains the best clinical tool in the evaluation of neonates.⁶⁴ With the arrival of important personnel and the development of new technologies, Apgar was able to build on her technique and make several other important advances in the field of obstetric anesthesiology. Later in life, she changed course once again, earning a

⁶³ See Lamb, *Presbyterian Hospital*, p. 359-360, for a different account of the establishment of the Department of Anesthesiology at Presbyterian, the problem of Dr. Apgar's salary and the patient charges for anesthesia. His emphasis is on legal barriers to anesthesia fees, rather than on power structure that may have accounted for the existence of such legal barriers.

⁶⁴ The method calls for the evaluation of the newborn in five categories – respiratory effort, reflex irritability, muscle tone, heart rate, and color – on the scale from zero to two. (More, *Restoring the Balance*, p. 180.)

masters in public health and becoming a director of the National Foundation's (previously the March of Dimes) new division of congenital defects.

Pondering her remarkable career, Selma Calmes summed the mixture of constraints and opportunities as follows:

As a woman, Apgar could not be a surgeon so she entered anesthesiology, which needed physicians. When she could not be a department chair, she entered obstetric anesthesia where, once again, there were great needs. This move freed her from administration, and allowed her to make her greatest contributions. A chance remark led to her formulation of the Apgar Score in 1949. The arrival of important personnel and the development of new technology for measuring blood gases, pH, and anesthetic blood levels made further development of the Apgar Score possible. There was a reciprocal relationship between Apgar and the developing field of anesthesiology during the Columbia years. She needed the opportunities available in this specialty and anesthesia needed her contributions.⁶⁵

A woman of exceptional character and talent, Apgar had also foregone family life. Of her decision to remain single, she said, "It's just that I haven't found a man who could cook."⁶⁶ Perhaps in virtue of her personal exceptionalism, or the imperative to survive in the very difficult circumstances, Apgar did not see structural barriers which kept women out of full participation in medicine and other professional fields. According to Calmes, Apgar rarely recognized gender issues, and never in public.

She often declared that "women were liberated from the time they were born." She appears to have had little regard for women residents, and she never participated in female medical organizations. She felt she did not need them.⁶⁷

Only in rare diary notes and in private conversations did Apgar sometimes express outrage at such things as salary differentials between her and her male

⁶⁵ Calmes, "Virginia Apgar: A Woman Physician's Career in a Developing Specialty."

⁶⁶ Quoted in More, *Restoring the Balance*, p. 180.

⁶⁷ Calmes, "Virginia Apgar: A Woman Physician's Career in a Developing Specialty."

colleagues and the “stag” dinners that followed professional meetings. Like most women doctors of the time, she did not speak out about them, silently working with those opportunities which came her way.

Apgar’s career and views were in many ways typical of the few women who managed to break through into the academic medicine in the decades immediately before and after the Second World War. Their exceptionalism and isolation, combined with the dearth of feminist consciousness and fragile foothold in the institutional ladders, typically prevented them from appreciating the full scale of gendered discrimination and injustice in the medical field. With few exceptions, women have not achieved a position from which to increase their numbers and had often were even lacking a disposition to do so.

Despite the steady marginalization of women in medicine, the point of breakthrough came in the 1970s. It was not limited to the health care field, but encompassed in its effect the entire economy of higher education and the white-collar occupational fields. Its source was the rebirth of political feminism which was inspired in turn by the Civil Rights struggle of the 1960s.⁶⁸

Titles VI and VII of the 1964 Civil Rights Act banned discrimination on the basis of race and sex but exempted colleges and universities from compliance. President Johnson’s executive orders 11246 (1964-1965) and 11375 (1966-1970) barred sex discrimination in federal employment and among contractors to the federal government, but their effect on women faculty and students of medical schools was slight. Despite their dubious reach, the Women’s Equity Action League (WEAL) filed two class action suits in the course of 1970, first against 250 colleges and universities and then against all of the medical schools in the country. Partly as a result of this

⁶⁸ More, *Restoring the Balance*, p. 216.

offensive, in October of 1971 Congress passed the Public Health Service Act which included a provision barring employment discrimination in medical and other health professions schools. The Equal Employment Opportunity Act of 1972 overturned Title VII's exemption of institutions of higher education. Finally, in June of 1972, Congress passed Title IX of the Higher Education Act, banning discriminatory admissions and employment policies in any institution receiving federal funding.⁶⁹

The general climate of outrage at the decades of stalled progress of women and minorities, rather than the legal merits of the particular suits, were likely responsible for this remarkable breakthrough. In fact, if a few medical schools clearly remained quite closed to women, at the collective level discrimination in medical education was impossible to prove. The testimony used by WEAL in regard to medical school admissions and furnished by the representative of the AMWA appears to have been indeed incorrect. Specifically, the testimony noted that since the 1930s the number of women applications to medical schools had risen by more than 300 percent, while the number of men who applied had increased only by 29 percent. Despite this disparity, the rate of admission for women had remained at a steady 50 percent, a result, as it was charged, of “an *arbitrary grouping of applicants by gender*.”⁷⁰

It appears, however, that the story was much more complicated. The numbers show that between 1935 and 1960, the rate of increase in the number of female and male applicants was virtually identical. Their acceptance rates were also close, differing in at most two percentage points, which is how the proportion of women among medical students could have been kept steady throughout this period. In fact men's and women's rates of admission to medical schools would continue to be the

⁶⁹ *Ibid.*, pp. 217, 218.

⁷⁰ Quoted in More, *Restoring the Balance*, p. 217, from “Statement of Frances S. Norris, M.D., before the Special Subcommittee on Education Re: Sec. 805, H.R. 16098, concerning Discrimination against Women in Medical Schools,” pp. 1-4.

same for the rest of the century. The only difference would be that, after 1975 the number of female applicant would sky rocket, while the number of male applicants would decline not only proportionately, but even in absolute numbers.

It seems, then, that both before and after the breakthrough, the gender composition of the medical schools was shaped at the level of the total number of applicants. The entire picture of the system of career signaling which accounted for the size and composition of applicant pools cannot be reconstructed from the available data, but it appears to have included strong elements of positive or negative advising and major-tracking at the college levels, as well as published and unpublished remarks of the medical schools, which infrequently included unabashed statements about preference of male students.⁷¹ Both the reluctant tone of admissions literature and the cautionary stories of the advisors and women who have entered medical schools collectively created the impression of the medical training as a particularly arduous ordeal for women. Combined with not so certain career prospects, this negative advertising must have accounted for the steadiness of the women's proportion among all applicants.

What happened after 1975 was equally amazing. In a very short time, there was an entirely new system of career signaling in place. It persuaded women to quadruple the number of their applications to medical schools in ten years, while compelling men to reduce theirs by over 10,000 applications per year, or over 30 percent, during the same period.

More importantly, perhaps, there was a change in the terms of women's participation and in their views of their situation. There was far less amusement at the

⁷¹ More, *Restoring the Balance*, p 218. According to More, as late as 1963 15 percent of medical schools expressed a preference for male applicants in a handbook published by the Association of American Medical Colleges.

misogynist remarks of the faculty or administrators and much less tolerance for the institutionalized practices of women's marginalization. The questions of paternalism and harassment, women's mentoring and skewed specialization were now being openly raised. These new attitudes have been well captured in the report issued by two women students at P&S in October 1977. Entitled "Double Image," the report explored the status of women and minority students at the College and found it ridden with problems of neglect, disingenuousness, and harassment.⁷²

So was there a discrimination on the part of Columbia? Both on paper and in interviews, women were likely systematically better than men. In this case, then, their rate of admission, which was almost as high as that of men, was likely discriminatory. Of course, in virtue of their sex, women were likely substantially discounted in regard to their future potential. Admissions officers likely thought that both women's family roles and the likely discrimination they may encounter in their future careers would render them less professionally successful than men. Such a 'future discounting' presented a considerable moral problem, because Columbia, like all other institutions, was itself contributing to women's lower professional success. Recognizing this dilemma, a socially responsible institution would feel an obligation to do more than its share in both admitting women to the study of medicine and in ensuring the fair treatment of women in post-graduate and other professional posts within its institutional walls. It would also find it necessary to try to influence other related institutions to do the same. This, I believe, is a yardstick by which the record of the institutions should be judged and, in this view, Columbia could have done considerably more. The steady adherence to the under 10 percent quota of female students is incomprehensible in itself.

⁷² "The Double Image."

Ethno-Religious Identity

In an intensely nativist climate of the 1920s that saw the enactment of many immigration restriction laws, widespread biases existed in the admission of Catholics, Italians, Irish, Slavs, Jews, and other ethnic or religious minorities to most branches of higher education and professional practice. By virtue of their success in climbing the educational and social ladders, the most systematic quotas were faced by the Jewish applicants. Discrimination was most intense in New York, where the number of applicants was the highest.

Between 1880 and 1925, the Jewish population in the United States increased from 200,000 to over 4,000,000, and Jewish youths sought admission to colleges and professional schools in high numbers. In places like New York, with a high concentration of immigrants, the numbers of qualified Jewish students who applied to colleges and professional schools have risen sharply by the 1920s. Some New York colleges, particularly the City College, had a majority of Jewish students and even the best medical schools in the City – Cornell and Columbia – found over forty percent of their classes Jewish. The WASP elites, entrenched in the institutions such as Columbia, were threatened, reckoning that if they instituted blind admission processes, some schools – notably, those of medicine, pharmacy, and the law – would soon be overrun, as they put it, by the Jews.

With the still high percentage of foreign-born or first-generation Americans within the City's Jewish community, all sorts of horrors, including un-American culture, foreign influence, even socialistic ideas, were implicated in such an outcome. The fact that the new wave of Jewish immigrants came from Eastern Europe rather than Germany as the earlier one had been was only adding to the prejudice against them. The plain fact was that they were newcomers who dared to challenge the established elites through the channels of education. Eastern European Jews were

violating the unspoken rules of massive immigration from the lesser developed countries: that the newcomers should for a long time pay their dues, by occupying the lowest social positions in their new society, and that they remain a minority in the more rewarding pursuits. While there was a lot of poverty and hardship undergone by the East European Jewish immigrants, they were succeeding like few other groups before them in securing education for their children and quickly improving their social standing.

Very soon, a backlash began. The first manifestation was the creation of quotas at many elite private colleges. Soon quotas appeared in medical schools and other areas of professional and graduate training. By the late 1930s and early 1940s, rigid quotas were found throughout medical education. When the rejected Jewish applicants resorted to the foreign medical school route, the American Medical Association had withdrawn its approval of a large number of the European institutions which were more liberal in their acceptance of American students, making it impossible for their graduates to obtain licenses to practice in the United States. Repelled from the medical schools by the stiffening quotas, the Jewish youths have turned to related professional paths, including dentistry and pharmacy. Whenever that was within the power of the medical profession, it tried to establish Jewish quotas there as well.⁷³

⁷³ One of the prominent investigations into the allegations of discrimination, the Hart Committee, included the following testimony of Dr. Allen T. Newman, Dean of the NYU Dental School, who resigned in May 1944 as a protest against rulings by the American Dental Association on students to be accepted. "Up to May, 1944, there was no discrimination whatsoever in the admission of students. They were selected wholly on the basis of scholastic records and aptitude tests. During the 15 years that I was a dean there was a preponderance of applications from boys of Jewish faith and, of necessity, the student body was preponderantly Jewish. I was condemned for permitting such a condition to exist and therefore I resigned." (*Daily News*, December 24, 1946.) Another report noted that the overall picture of discrimination against American Jewish students was far worse than the statistics drawn from any particular groups of institutions, or even of only American institutions, would indicate. It explained that "[s]ome Jewish students have, in the past, managed to get into medical schools via some elaborate detours. In 1936, for example, an investigation showed that there were among the Jewish physicians practicing in New York City, graduates of many European medical schools. This avenue of entry into

After the end of the war, the continued existence of the quotas aroused a struggle, as some Jewish groups organized to fight against them. Throughout this period of public allegations, investigations, and efforts to reform New York's system of higher education, the medical schools, Columbia included, vehemently denied the existence of either quotas or discrimination. Discriminatory limitation was fairly easy to achieve but difficult to prove. Into the late forties, medical school application forms routinely asked for photo, nationality, birthplace and even father's birthplace of the applicant. Applications from the graduates of certain colleges known to have a very high proportion of Jewish students, such as the City College of New York, could be viewed with disfavor. Since the city and the state of New York had an especially high number of Jewish applicants, schools could use the goal of a geographically diverse student body as a disguise for anti-Semitism. Similarly, an insistence on accepting students of only the proper "character" for medicine could also be used as an effective cover for ethno-religious discrimination.

While Columbia has flatly denied discriminatory practices, its records tell a different story and also shed light on the larger picture of how the academic and professional medical institutions have shaped their memberships.

Columbia's files on the charges of discrimination began with an interesting copy of the correspondence. The letter was from Morris Fishbein, the editor of the *Journal of the American Medical Association* and a powerful spokesman for the

the field of medicine has since been closed both because of the War and because of increasing difficulties of American graduates in European institutions in obtaining licenses to practice in New York State. The American Medical Association before World War II withdrew approval of a large number of the European medical schools which were more liberal in their acceptance of American students. A large number of Jews desiring to become doctors have perforce attended Grade B medical schools. Here, too, the detour has been closed by virtue of the impossibility of obtaining licenses to practice. Many other Jewish students have detoured into medicine via the path of spending several years in dentistry schools or in the pursuit of higher degrees in fields bordering on medicine. Such detours are becoming increasingly difficult." (Mayor's Committee on Unity, "Report on Inequality of Opportunity in Higher Education," pp. 14-17.)

organization, to Arthur Garfield Hays, a prominent attorney and the subject was the problem of the Jewish boys in medicine and, more specifically, a possibility of pressing for matriculation of the number of Jewish-American medical students enrolled in the Scottish medical schools to the domestic institutions.

Since I have returned home from my trip to the Northwest I have looked into the matter about which you talked to me when I was in Yakima.

All the evidence which we can secure indicates that the extramural schools in Scotland which most of these boys have been attending are of a rank distinctly inferior to the American medical schools. Inasmuch as there are thousands of boys on the waiting list for medical schools in this country, many of them far better qualified than these boys who are left the United States to study in Scotland because they could not get into medical schools in the first place, I do not see how or why any one ought to exert a terrific effort to force American medical schools to take them in. After all, our first duty is to the people of the country who are entitled to have the highest quality of medical service that they can get.

I feel bad indeed about these boys, yet everyone suffers in time of war, and there is no way to overcome an emergency. The case of the Jewish boys in medicine is particularly serious because they have overwhelmed the schools, and many schools turn them down simply because they are Jewish. There is no way to prove this, but it is obvious.

At the same time, I wish to point out that somewhere between 15 and 20 per cent of the doctors in this country in the practice of medicine are Jewish, and there is about 3 ½ per cent of the population in the same category. If the Jewish boys would all go out into the rural communities where doctors happened to be needed, they might be encouraged to go into medicine. Unfortunately they elect to settle in the large communities. When they settle in the large cities, they find it difficult to secure practice. This makes for a lowering of ethical standards. The problem has so many ramifications, as you can see, that it is exceedingly difficult to know just what to do.

However, even if all of this were not the case, the fact still remains that the Council on Medical Education and Hospitals of the American Medical Association has no authority in the matter. We are not in a position to tell schools whom to take in. All that we do is to inspect the schools and to determine that they are selecting a high quality of men and maintaining minimum standards. We exert no pressure on them to accept or reject any one. Indeed, there is no way in which we could do this.⁷⁴

⁷⁴ Morris Fishbein, *The Journal of the American Medical Association*, 535 Dearborn Street, Chicago to Mr. Arthur Garfield Hays, New York City, October 7, 1939.

Fishbein's conclusion about the Scottish schools was probably particularly pleasing to Columbia's Dean of Medical School, Willard Rappley, who happened to have been personally involved in the withdrawal of their approval and received several angry letters from the superintendents of the Scottish Extra-Mural Medical Schools whose recognition by the AMA was withdrawn following Dean's alleged visits of inspection. A letter from one superintendent stated that he had no record of Rappley ever visiting his school. Another superintendent angrily recognized the "Jewish problem" behind the whole unpleasant incident:

Looking into the whole circumstances and with the special knowledge one has with regard to the situation, it is impossible to resist the conclusion that this so called inspection was a mere pretext. It is, in my view, an attempt to deal with what is really a U.S. question on his side of the Atlantic and an action of this sort taken against a sister Corporation in a very sinister one and is resented. This points to the U.S. question to which I refer are twofold; - firstly, that a larger number of you people in American are seeking admission to American Medical Schools than the Schools can handle, and secondly, that racial discrimination enters largely into the question.⁷⁵

It was quite clear that there were many more qualified Jewish applicants than the American schools cared to admit. The problem was known to everyone in the medical education establishment, yet when the public charges of discrimination were brought up, Columbia, along with most other institutions, sought to deny them in absolute terms.

The earliest records of public charges in Columbia's files date to the spring of 1946. On March 15th, The New York Sun reported that Dr. Stephen S. Wise, President of the American Jewish Congress, filed an application with the New York

⁷⁵ Photostats, all names blackened out in Box 623 Discrimination 1946-1950s, Folder 623 Newspaper Clippings.

City Tax Commission to cancel the tax exemption granted to Columbia, charging the school with racial discrimination.

Ten days later the *New York Times* reported that

Tax Commission will not act on petition by Wise to cancel CU's tax exemption, announced Harry B. Chambers, president of New York City Tax Commission because of pending litigation – a suit by Julius L. Goldstein resulted last June 14 in a decision by Supreme Court Justice James B.M. McNally that discrimination ... is not grounds for canceling tax exemption. [of non-sectarian educational corporation.] His decision held that "... legal remedy provided must be exercised by the persons aggrieved."⁷⁶

The attack would not, however, be brushed aside so easily. In May of 1946, Rabbi Wise urged the City Council to open an investigation into racial discrimination in colleges and university schools, singling out Columbia again. He noted that he studied at Columbia for ten year and "he made the charge with great reluctance." Nevertheless, he accused the University of practicing racial discrimination "in a manner slyly and subtly concealed" and called with revoking its two millions worth in tax exemptions if discrimination does not cease.⁷⁷ Another petition, by Julius L. Goldstein, to remove Columbia's tax exemption was filed on May 27th, to keep the process going.

In July, the Mayor's Committee on Unity issued a Report on Inequality of Opportunity in Higher Education, which concluded that the available evidence suggests the existence of discrimination and called for "a thorough-going investigation of the policies and practices of institutions of higher learning in New York State."⁷⁸

The interim report of the Hart Committee concluded that "the evidence is inescapable that the Cornell Medical School, Columbia College of Physicians and

⁷⁶ "Case in Court Bars Action on Columbia," *The New York Times*, March 26, 1946.

⁷⁷ "Bias Inquiry into College Is Urged on City," *Herald Tribune*, May 18, 1946.

⁷⁸ Mayor's Committee on Unity, "Report on Inequality of Opportunity in Higher Education," pp. 14-17.

Surgeons, Long Island College of Medicine, New York University School of Medicine and New York Homeopathic Medical College discriminate against the graduates of city colleges.”⁷⁹ By examining the registrars of the several schools, the committee endeavored to show that the institutions arbitrarily limited the number of students from New York City, saying that “[t]he application of any quota, geographical or otherwise, would directly result in discrimination against students of the various racial origins predominant in the city of New York.” The report also noted that there appeared to be a trend to increase the number of questions, included in application forms, which aimed at eliciting information pertaining to applicant’s religion and nationality. Columbia’s application form for 1947, for instance, required a photograph, place of birth, citizenship, father’s occupation and father’s birthplace.⁸⁰ The committee also dug out some musings over the question of alien students and un-Americanism, which some schools have put in print in the 1930s. The report quoted some passages from “History of New York University, 1832-1932,” to the effect that “in 1919 the faculty agreed that the university’s quality of ‘Americanism’ was in danger.” In 1932, continued the passage, “we are perhaps less sure of what ‘Americanism’ is but we can probably admit that the university college was being swamped in 1919 by an invasion of students of what, to older American students and teacher, seemed wholly alien habit and manners.”⁸¹

While a number of petitions, investigations, reports, and resolutions were flung around the power center of the City and State, Columbia’s strategy of defense included several elements. First, its legal counsel successfully argued in the courts

⁷⁹ “Urges Erasing of Race Lines: Council Committee Studying Discrimination in Colleges Calls for Legislation,” *The New York Sun*, December 23, 1946.

⁸⁰ Columbia University, College of Physicians and Surgeons, 630 West 168th Street, Application for Admission to First Year Class in September, 1947, 6 pages.

⁸¹ “Urges Erasing of Race Lines: Council Committee Studying Discrimination in Colleges Calls for Legislation,” *The New York Sun*, December 23, 1946.

that tax-exemption of non-sectarian educational institutions was not predicated on the requirement of non-discrimination, but only on “exclusive ownership, exclusive use, and non-profit making.”⁸² Second, although their legal strategy was to deny that non-discrimination was their obligation in return for non-profit tax status, both the University and its medical schools flatly denied any discrimination on the basis of race or ethno-religious identity. These stone-faced denials have angered some of the Jewish alumni and former associates. Dr. Harold Thomas Hyman, an alumnus and a former faculty member of the College of Physicians and Surgeons have made public the following letter to Columbia’s Acting President.

The New York Times of May 18th (pg. 19, Col. 1), in its report of the public hearing before the Rules Committee of the City Council, quotes you as stating that “Columbia University has always been, and now is, strongly opposed to any discrimination whatever against any person by reason of race, color or creed.” Later in the same report, Dr. Rappleye declared that applicants for admission to the College of Physicians and Surgeons were judged on the basis of “highest promise of becoming sound, ethical, well-trained and competent practitioners of medicine and leaders in the medical profession.”

When the resolution to take steps to end the tax exemption privileges of Columbia University, as sponsored by Councilman Eugene P. Connolly, first came to my attention, I permitted loyalty to my Alma Mater and selfish personal discretion to influence me to stay aloof from these public hearings despite my intimate knowledge, from my twenty-five years of experience as student and teacher at the College of Physicians and Surgeons, of the truth of the charges of discrimination against applicants because of race color or creed.

The crass and brazen falsity of your statement and the characteristically suave and misleading evasiveness of Dr. Rappleye leaves me no honorable alternative other than to place myself at the disposal of the Committee before whom I shall, if requested, give first-hand testimony of the truth of the situation as I have seen it, as well as supplementary data that may be of even

⁸² Statement of John Godfrey Saxe appearing for the President and Trustees of Columbia University; City of New York, City Council – Committee on Rules, Privileges and elections, In the matter of Resolution no. 128, Resolution Urging the New York City Tax Commission to Immediately Investigate Charges of Discrimination Against Columbia University and to take steps to withdraw tax exemptions from Columbia University if charges are found to be true. Honorary Walter R. Hart, Chairman, presiding.

greater interest to the taxpayers of our City who, like me, have steadfastly supported Columbia University and who wish now to protect that institute of learning from those who would use it for undemocratic purposes.⁸³

Finally, the University and the Medical School engaged in public relations campaign, the cornerstone of which appeared to be the close acquaintance of Dr. Fackenthal's one of the prominent members of the Jewish community and the publisher of the New York Times, Mr. Arthur Hays Sulzberger. Secretive correspondence from Columbia's Acting President, thanking Sulzberger for "transmitting the reports of the two 'guinea pigs'" and discussing what can be done "informally" about the American Jewish Committee, suggests a careful campaign to set the record "straight" with at least a portion of New York's Jewish community.⁸⁴ Another letter from Dean Rappleye furnished Sulzberger with Columbia's internal estimates of the number of Jewish students, disputing American Jewish Congress' data of precipitous decline of Jewish admissions at Columbia, as shown in Table 5.2.⁸⁵ The information was likely intended for transmission to certain members of the Jewish circles who appeared to show "their own satisfaction with our situation" and could be helpful in diffusing the wave of attacks.⁸⁶

⁸³ Dr. Harold Thomas Hyman, 940 Park Avenue, New York City to Mr. Frank D. Fackenthal, Acting President, Columbia University, New York City, May 20, 1946.

⁸⁴ Frank D. Fackenthal, Acting President, Columbia University, New York City to Mr. Arthur Hays Sulzberger, 229 West 43rd Street, New York 18, New York, August 20, 1946.

⁸⁵ Table attached to Rappleye to Mr. Arthur H. Sulzberger, New York Times, Times Building, New York, N.Y., September 25, 1946.

⁸⁶ Rappleye to Mr. Arthur H. Sulzberger, New York Times, Times Building, New York, N.Y., September 25, 1946. The quote is from Fackenthal to Sulzberger, August 20, 1946. In a fascinating new book on the New York Times' coverage of the Holocaust, [Laurel Leff, *Buried by the Times: The Holocaust and America's Most Important Newspaper*, (Cambridge: Cambridge University Press, 2005)] the author tells us that Arthur Hays Sulzberger refused to join a Jewish fraternity at Columbia and refused to join the American Jewish Committee. In 1934 Sulzberger wrote: "I am a non-Zionist because the Jew, in seeking a homeland of his own, seems to me to be giving up something of infinitely greater value of the world ... I look askance at any movement which assists in making the peacemaker among nations merely a national warrior." (This information is drawn from the book review article "The Legacy of Arthur Hays Sulzberger" by Ira Stoll in the archives of the Jewish Ledger, published by the New York Sun News Service, on the web at http://www.jewishledger.com/articles/2005/07/07/book_reviews/book09.txt.)

Table 5.2. *Proportion of Jewish Students Enrolled at Columbia University's College of Physicians and Surgeons, 1920-1946: Internal Institutional Claims*

Year of admission	Enrollment reported by A.J.C.*	Correct figure	Number of Jewish students (A.J.C. figures)	Our opinion	Percentage of Jewish students	
					A.J.C.	Our opinion
1920	98	94	46	Not checked (probably close to figures of A.J.C.)	46.92 %	47 %
1924	108	108	20		19.2	19
1928	112	108	23		20.24	20
1932	88	112	22		33.60	20
1936	103	116	6	23	5.82	21
1940	124	110	8	24	6.40	22
1944	not given	116	not given	32	-	28
1946	not given	111	not given	29	-	27

* American Jewish Congress

Source: Table attached to Rappleye to Mr. Arthur H. Sulzberger, New York Times, Times Building, New York, N.Y., September 25, 1946.

Through Mr. Sulzberger, Columbia's officials also had an opportunity to influence the preparation of the manuscript for a proposed article on discrimination to be published in the *New Republic*. University's legal counsel received the portion of the manuscript dealing with Columbia for comment. The portion noted that the attitude of Columbia was of particular interest, one of them being that "General Eisenhower will become head of that institution early next year." If the General has presidential ambitions, as the author believed he had, "the question of discrimination at Columbia might come to have political significance." After successfully negotiating a deal that the part on Columbia would include "the answer of 'a spokesman for Columbia' which clarified the situation," the University won an even more favorable disposition. The editor of the *New Republic* informed the University's

representative that “in view of President Truman’s Committee report he has decided to eliminate the part on Columbia entirely.”⁸⁷

For all its unreality, Columbia’s strategy must have worked reasonably well because soon the bulk of the attention had shifted to Cornell’s medical school which was not nearly as careful. In the fall of 1946, a copy of the letter written by the former dean of Cornell’s medical school and which addressed the issue of Jewish admissions was found and submitted to a special City Council committee chaired by Walter R. Hart. Written in 1940 in regard to the rejection of admission to a particular Jewish applicant, the letter said in part:

Cornell Medical College admits a class of eighty each fall. It picks these eighty men from about twelve hundred applicants of whom seven hundred are Jews. We limit the number of Jews admitted to each class to roughly the proportion of Jews in the population in this State, which is a higher proportion than in any other part of the country. That means we take in from 10-15 per cent Jews.⁸⁸

In the circus of accusations and investigations, honesty was dangerous and sounded pathetic, as the report of the questioning of Dr. Charles O. Warren, a former member of Cornell’s admissions committee had shown.

Dr. Charles O. Warren, a member of the admission committee in 1945-46 until he left the college last August, had difficulty in explaining testimony he had given in private. With Mr. Hart constantly reading his private testimony, Dr. Warren testified that when he said the religious of applicants had been “discusses” by committee member, he meant it had been “mentioned.” He said he could not answer “yes or no” to a question whether he was prejudiced against Jews, but admitted to a prejudice, though a mild one, against the Irish. He insisted emphatically that he had never consciously allowed whatever

⁸⁷ John G. Saxe to Arthur Hays Sulzberger, Esq., Times Building, New York, October 31, 1947.

⁸⁸ “Race Bias Charged at Cornell School: Former Medical Dean’s Letter Cited to Show Limitations on Jewish Students in 1940,” *The New York Times*, October 23, 1946.

prejudices he had to affect his decision on any applicant. He said he believed everyone has prejudices.⁸⁹

The rest of the testimonials from Cornell's officials denied any and all discrimination and quotas but their strategy was clearly not as consolidated and smooth as that of Columbia.

Following this mess, Columbia's public relations campaign incorporated spying on the open meetings concerned with educational discrimination. A spy report of one such gathering, the Meeting of the Physicians Forum on the subject of Discrimination in Medical Schools held at the New York Academic of Medicine, contained the information on the speakers, statistical figures presented, as well as a personal assessment of Councilman Hart characterized as "a pretty smooth operator" who "has his teeth into something which looks like a red plush carpet Valhalla."⁹⁰ The reporter came away "even more convinced of the importance of our doing a constructive, aggressive and understandable public relations job." The uncareful strategy of the other accused schools, Cornell in particular, made the situation considerably worse.

For out of the testimony of many of the Deans and members of the Admission Committee last Fall, Councilman Hart has some pretty powerful, "on the record" ammunition. It will be a long time before we hear the end of the curious statements attributed to Drs. Hinsie, Edwards, Flood, Morton, Warren, etc. His particular targets, in an extremely skillfully organized address, were Hinsie, Warren and Theodore Francis Jones. I must say that the content of their testimony as read by Mr. Hart is a pushover for ridicule in the name of Democracy.⁹¹

⁸⁹ "Race Bias Charged at Cornell School: Former Medical Dean's Letter Cited to Show Limitations on Jewish Students in 1940," *The New York Times*, October 23, 1946.

⁹⁰ Anonymous, "Report of the Meeting of The Physicians Forum on the subject of Discrimination in Medical Schools held at the New York Academy of Medicine, 8:30 p.m., March 13, 1947." The report appears to be addressed to Dean Rappleye as is clear from the following sentence. "In this connection he particularly referred to you (Dr. Rappleye) and quoted you elsewhere only at one point." (p. 3)

⁹¹ *Ibid.*

Columbia and Columbia's officials, on the other hand, fared much better at the meeting. Throughout the meeting Mr. Hart "made repeated points to emphasize the fact that 'since the beginning of our investigation the medical schools have complied with every request we have made'" and, in this connection, referred particularly to Dean Rappleye. The only other mention of Columbia was in connection with what "he call[ed] the 'destruction of our records' – the application blanks of those who were rejected by the Committee on Admissions." Incidentally, the spying mission included reporting on one of Columbia's own, Dr. Viola Bernard, who was the last speaker on the program. According to the anonymous reporter, it was quarter to eleven by the time she was to speak and s/he did not wait for the speech "beyond her introduction that indicated that her emphasis was to be laid upon the problem of women doctors after graduation in obtaining internships, residencies, and hospital appointments."⁹²

By 1947, the battle shaped up to include an Austin-Mahoney anti-discrimination bill in the state legislature and also a proposal to create a State University, in part as another measure to assure residents of the state equal educational opportunity. Columbia's officials have gone to work against both measures as part of the acknowledged leaders of the New York State Association of Colleges and Universities. The paper delivered by Provost Jacobs for Dr. Fackenthal at the meeting of the association is interesting in several respects.⁹³ The speech served as an overview of the recent developments leading to the formulation of the Austin-Mahoney Bill and a summary of the position which the Association developed in its regard. The first part of the speech was rather distasteful. Firstly, as the following

⁹² *Ibid.*

⁹³ Paper by Provost Jacobs at recent meeting of New York State Association of Colleges and Universities, November 23, 1947.

excerpt shows, it has painted the entire episode of allegations and legislative proposals as a work of one interested group, the American Jewish Congress.

In 1946, late in the legislative session, the American Jewish Congress announced in the press that on the previous day it had caused to be introduced in Albany a bill known as the Austin-Mahoney Bill. No serious attention was paid to this measure at the time. But after the 1946 Legislature had adjourned, the American Jewish Congress started an active campaign in support of such legislation. From April, 1946, until the early autumn it conducted the campaign in its own name, and during this period, caused to be drafted several widely different versions of the original Austin-Mahoney Bill.

In the early fall of 1946, with the gubernatorial election approaching, the AVC decided that it would be more effective to organize a so-called “non-sectarian” group to further its legislative proposals. It caused to be organized the New York State Committee Against Discrimination in Education, which is, in effect, but an arm of the American Jewish Congress. Its office was a room in the suite of the American Jewish Congress and one of its chief and most active representatives was and is Mr. Shad Polier, the son-in-law of Rabbi Wise, the President of the American Jewish Congress. From September, 1946, the American Jewish Congress, under Rabbi Wise, and the newly-formed Committee Against Discrimination, through Mr. Polier, waged an active campaign for an Austin-Mahoney Bill, and at the opening of the 1947 legislative session, such a bill was again introduced. In some respects this bill was different from the earlier versions, but in most respects, and fundamentally, it was just as bad; as indeed any legislation of this nature must necessarily be.⁹⁴

The speech had also endeavored to paint the American Jewish Congress as a shrewd and aggressive political pressure group, while the Association, its members, and its supporters, such as the Catholic Church, as politically naïve but, when pressed, courageous institutions.

From September, 1946, up and through February, 1947, every effort was made by the proponents of this bill to arouse public support for it. Prior to mid-February, 1947, little was done by anyone to oppose it. I think it is fair to say that most educators, although they were vitally concerned, had not seriously considered the bill; and indeed many of us had not even read it.

⁹⁴ *Ibid.*

While the colleges and the great mass of the public slept, the American Jewish Congress and its satellite, the Committee Against Discrimination in Education, left no stone unturned. They conducted petition campaigns, held mass meetings and sponsored marched on Albany.

It was known that the great majority of the legislators opposed any such measure. But they were being subjected to such a bombardment by the pressure groups sponsoring the bill, without any help from those who should have been opposed to it, that in mid-February passage appeared inevitable. Then two things happened. The first was the courageous and outspoken stand of the Catholic Church. The second was the opposition voiced by this Association. The Church's opposition was expressed in the form of a public statement by the Catholic Welfare Council, issued on February 26th. The opposition of the Association was conveyed to the Governor and legislative leadership, and announced to the press on February 28th. A number of leading citizens of the State and other groups who had awakened to the danger of the proposed legislation, also joined in the opposition. The bill died a few days later.⁹⁵

The opposition of the Catholic Church, to which the speech referred with such enthusiasm, was cleverly calculated punch below the waistline. Delivered unannounced at the clerical meeting, the position of the Church of course had nothing to do with the goal of eradication discrimination as such. After all, mentioned Archbishop McIntyre, Catholics have been victims of discrimination as well. The Church opposed to the Austin-Mahoney bill as one "formed after a Communistic pattern."

The bill states that education is the function of the State. Education is not the function of the State. Education is the function of the parent. If the statement that education is a State function is written into law, it will permit future encroachments on the parental functions of education. That is what we mean by the infiltration of Communist ideas. The bill is formed after a communistic pattern which would be detrimental to future generations.⁹⁶

⁹⁵ *Ibid.*

⁹⁶ "Archbishop Scores Anti-Bias Measure: McIntyre Says Church Finds the Austin-Mahoney Bill Communistic in Pattern," *The New York Times*, March 3, 1947.

Chad Polier issues a reply to Archbishop McIntyre, noting that the proposed bill would not apply to sectarian schools:

To label public responsibility for education ‘communistic’ is to undo more than a century of American tradition and practice. Such labels as Communistic and un-American will not persuade this country to set the clock back to the day when education was considered a purely private concern. Nor will these labels obscure the single purpose and the complete soundness of the Austin-Mahoney bill. That purpose is simply to assure that no parent will be deprived of the opportunity to send his child to a non-sectarian school because of his race, color, creed or ancestry.⁹⁷

In his speech, Columbia’s Provost denied the existence of discrimination at the state’s institutions of higher learning, although he did choose his words carefully.

When the colleges and universities are charged – as they have been – with admission practices that are discriminatory rather than discriminating, it is of the first importance that the facts be ascertained and studied in perspective. I believe the facts will show that they are exercising their trust, in good faith and with honesty of purpose, and that the spectre of discrimination is small indeed. The few instances of discrimination that may have occurred, and it is remarkable in these days of tension and overcrowding that there have not been more, are infinitesimal in comparison with the thousands of persons belonging to minority groups who have enjoyed the benefits of our independent educational facilities. I endorse the Statement that there is no such thing as a policy of discrimination on the ground of race, color, creed or national origin.⁹⁸

He also endeavored to give a positive definition of what the process of student selection should be, and had presumably always been, at the institutions united into the Association.

The objective of our institutions has been and continues to be a student body of high quality composed of a cross section of the population and representative of all races, religions and social classes. Our objective has also been to minimize prejudice and to teach young people of different faiths how to

⁹⁷ *Ibid.*

⁹⁸ Paper by Provost Jacobs at recent meeting of New York State Association of Colleges and Universities, November 23, 1947.

understand each other and to live together in an integrated community. No institution today can admit all applicants and any interference with its own sound judgment in selecting students would impair its usefulness in providing educational opportunities for all classes and races.⁹⁹

The speech particularly objected to the part of the proposed bill which would make it illegal for educational institutions to solicit information concerning race, religion, color or national origin of an applicant. The speech quoted another educator's argument to the effect that it is precisely by having this information that colleges and universities can make their largest contribution to fighting prejudice.

[A] college which is trying to overcome prejudice by building an unprejudiced community of undergraduates needs to know what representation is had of different groups and may need to select its members with a view to distributing them for educational purposes. This bill, if passed, would prohibit our selection of students whom we actively want because they represent minority groups with which we want our majority to become acquainted.¹⁰⁰

All this talk of crafting a representative student body and of bringing in the members of minority groups "with which we want our majority to become acquainted" was patently misleading in the case of charges of discrimination against Jews. In New York City, where the scandal has been centered, Jews if taken on their merits alone could have easily close to or even over half of the student bodies in many colleges and professional schools, as was clear from their numbers before the rise of the quotas. The whole discourse of "we need to know race, color and creed," so that we can increase minority representation sounded plausible only because there was

⁹⁹ *Ibid.*

¹⁰⁰ *Ibid.* The paper also contended that the prohibition on the collection of demographic data, which it said was systematically collected by the government agencies, would make it impossible for the institution of higher education to defend themselves from any and all charges of discrimination. "It would make it impossible for [the educational institutions] to defend against persecution based on any kind of so-called 'evidence', inadmissible at law or in equity, and also against lists of meaningless figures having to do with so-called 'pattern evidence.' Our institutions would be wholly without records to dispute such 'evidence' and figures and to show that they were false or erroneous."

another minority – namely, African-Americans – for whom this kind of ‘affirmative’ admissions process would have worked. Just as the institutions of higher education had systematically exploited the different and particular weaknesses of the undesirable groups, so it was now confusing their position on discrimination by means of substituting discourse applicable to underrepresented minorities to the issue of the group which was well-represented, yet, on its merits, deserved a higher rate of admission.

The speech concluded by denouncing any legislation that would make scholarship a decisive criterion of student selection.

No institution of learning can prosper if it is obliged by law to abdicate responsibility for its membership. Certainly it requires no special insight to detect in the legislative proposals the kind of coercion which would make it impossible for an admission officer to reject a minority applicant on the same group that he might find it necessary to reject others – namely, that for the purpose of a given institution, a particular applicant’s total performance and promise fail to measure up to the overall competitive standards set by successful applicants. He would be fearful of doing so because in effect the proposed legislation denies the validity of all competitive criteria save scholarship alone. To make scholarship by law the sole criterion for admission is arbitrary and unjust and would tend to increase rather than diminish prejudice based on racial and religious tension. Instead of equality of opportunity for all regardless of race, color, creed or national origin, the legislative proposals would favor minority groups and serve to intimidate the institutions with consequent unfair treatment of the majority.¹⁰¹

This again was a cleverly calculated step. In insisting that making scholarship a decisive factor would tend to increase, rather than decrease discrimination, the speech was again substituting the problems of the other minorities – namely, blacks and those others which had an overall lower socio-economic status – for the distinct dilemma facing the Jews.

¹⁰¹ *Ibid.*

The Jews were caught in the room of mirrors where the specific methods of discrimination which they were subjected to were continuously presented as the very means by which equitable representation of (the other) minority groups was to be achieved. Where scholarship was their strongest suit, it was proclaimed to be a factor that, if made decisive, would increase discrimination against (the other) minority groups. Where the race-blind admission process would have surely increased the Jewish rates of admission, it was argued that the knowledge of applicants' race was the only way to ensure the admission of student bodies that included equitable representation of (other) minorities.

By deliberately confusing the statuses of and discourses about the different minority groups, the colleges and universities were able to convince themselves and the public that they were not doing anything wrong in regard to the Jewish applicant, while also pretending that they might be doing something constructive for the other salient minority, the African-Americans. Alas, they were not. In the case of the overwhelming numbers of well-qualified Jewish applicants, arguing that scholarship alone should never be a deciding factor was convenient indeed. When it came to the battle over the numbers of black students, scholarship was all of a sudden the factor which explained why there were few to none enrolled in New York's medical schools.¹⁰²

¹⁰² The resolution of the conflict, in which Columbia was so prominently involved, was not to be complete for years to come, although some stages of the conflict have been settled for the time being. In April of 1948, the New York State Fair Educational Practices Act was signed into law. ("College Bias Law Effective Today: State Bars Racial or Religious Discrimination in Admission of Student Bodies," *The New York Times*, September 15, 1948.) The bill was sponsored by Senator Elmer F. Quinn, Democrat, of Manhattan, and Assemblyman Lewis W. Olliffe, Brooklyn Republican. The law made it an unfair practice for any institution of higher learning to discriminate because of race, creed, color or national origin. Religious or denominational institutions were allowed to obtain the right to limit the admissions to members of their own faith by filing with the State Educational Department a certificate that they have elected to be considered religious or denominational institutions. The bill was lauded as the first of its kind in the nation and, upon signing it, the State Governor Dewey said it represented "a further step by New York State to reduce obnoxious and undemocratic barriers based on religious belief or accident of birth." The Governor added that the bill was the product of two years of

Race

Like women, African Americans have also participated in the healing arts since colonial times. Most were informally trained slave practitioners, herbalists, and midwives but a few also practiced as apprenticeship-trained physicians. By the nineteenth century, according to historian Herbert Morais, “Negro women engaged in the general practice of medicine were frequently listed in plantation inventories as ‘Doctor.’” Several free African-Americans practiced in the northern states before the Civil War, being either self-taught or apprenticed in medicine. A few, like Dr. David J. Peck, who graduated from Rush Medical College of Chicago in 1847, were graduates of a college of medicine.¹⁰³ By 1860 nine northern medical colleges had begun to admit African American men. The first African American woman, Dr. Rebecca Lee Crumpler, received a degree from a college of medicine in 1864. The first black medical college, Howard University Medical College, was organized in

deliberation and study by the Commission on the Need for a State University which in fact “found that such discrimination existed in certain instances.” American Jewish Congress declared the act to represent a successful outcome of a two-year fight. Under the act, the State Commissioner of Education was empowered to investigate alleged unfair educational practices either upon a petition filed by an aggrieved individual or on his own initiative. The latter provision, enabling the Commissioner to order an investigation without waiting for a complaint, was lauded as the law’s chief advantage. In cases where the Commissioner was unable to eliminate a discriminatory practice by voluntary agreement, the law called for referring the matter to the Board of the Regents, whose final orders were said to be “reviewable and enforceable in court.”

Jewish organizations, including the Anti-Defamation League of B’Nai B’Rith and the American Jewish Committee, continued to produce studies documenting both improvements made in the wake of the scandals, such as the removal of potentially discriminatory questions from the application forms, and the continuation of discrimination against Jewish and Italian American applicants. (Anti-Defamation League of B’Nai B’Rith, 212 Fifth Avenue, New York, NY to Director to Admissions, School of Medicine, Columbia University, November 2, 1950 with “A Measure of Freedom,” Annual Report, reprint in a pamphlet form of a chapter “Cracking the Quota.”) The study published in 1957 charged that “instead of arithmetical quotas, ‘personality’ had become the device medical schools now used to continue discriminatory admission practices.” If applicants with top grades faced little difference in acceptance rates, among applicants with average grades, the ratio of rejection of Jewish students and Roman Catholics of Italian descent was more than double that of others. (“Hospitals Found Lacking Doctors: Almost a Third of Posts Are Vacant, Jewish Study Says – School Bias Charged,” *The New York Times*, June 2, 1957.)

¹⁰³ Herbert M. Morais, *The History of the Negro in Medicine* (New York: Association for the Study of Negro Life and History, 1967), pp. 10-31.

1869, and together with the second such institution, Meharry, became the training ground for the majority of African-American physicians. Still, the opportunities were enormously constrained. According to historian Darlene Clark Hine, in 1890 there only 909 black physicians in practice, of which 115 were women.¹⁰⁴

Until the 1950s, African-Americans attended medical school in very small numbers. Many schools, including several in the north, had never admitted a black medical student and it was not until 1966 were all medical schools desegregated.¹⁰⁵ During the interwar period, Howard and Meharry enrolled 87 percent of the country's black medical students, even as both schools were in severe financial circumstances.¹⁰⁶ Even the schools which admitted blacks took in appallingly low numbers. As late as the early 1960s, African-Americans comprised between 2 and 3 percent of all entering medical students, while the total proportion of black population was 10 percent.¹⁰⁷ Racial discrimination in medicine was hardly confined to medical schools. Most hospitals excluded blacks from internship and residency positions, even those that allowed African-Americans to work there as medical students. Internship opportunities for African-Americans were mainly provided by "colored hospitals." Very few residency positions for blacks existed, and these were found at only a handful of institutions.¹⁰⁸ Like women, African-Americans experienced frequent institutional discrimination, even when formally admitted into the training programs. They had a difficult time finding university housing and often had to eat in separate dining rooms. A particularly demoralizing obstacle for African-Americans was

¹⁰⁴ Darlene Clark Hine, "Physicians, Nineteenth Century," in *Black Women in America: An Historical Encyclopedia*, vol. 2, ed. Darlene Clark Hine, Elsa Barkley Brown, and Rosalyn Terborg-Penn (Bloomington, Ind.: Indiana University Press, 1993).

¹⁰⁵ Ludmerer, "Time to Heal," p. 63.

¹⁰⁶ *Ibid*, p.52.

¹⁰⁷ *Ibid*, pp. 249-250.

¹⁰⁸ *Ibid*, p.94.

insufficient clinical experience as hospitals often prohibited them from examining nonblack patients.¹⁰⁹

Little to no information is available on the black students or graduates of the College of Physicians and Surgeons prior to the 1940s. Before the Civil War, apparently, a young black slave, David K. McDonough, ended up studying at the College. As the story is told, this was occasioned by “a wager between two slave owners on a Black Man’s intellect, specifically whether a Black man could successfully complete medical training.” McDonough was sent to Lafayette College in Pennsylvania and graduated third in his class. He was admitted to Columbia College of Physicians and Surgeons, graduated and practiced in New York, “having won his freedom with the bet.”¹¹⁰

Almost a century later, the situation was scarcely better. In the decade between 1934 and 1944, only six Africa-Americans have been graduated from P&S and even this number may have been forced by the investigation into the plight of blacks opened by the medical society. Although publicly moot on the question, behind the closed doors many faculty members expressed the view that African-Americans were mentally inferior to Caucasians, and resolved that the school would admit only the most unusually superior applicants of the race.¹¹¹

¹⁰⁹ *Ibid*, p.74-75.

¹¹⁰ This information is taken from “History of Black Physicians,” by Esly Caldwell, II, M.D, on the web at <http://www.allaboutblackhealth.com/historyofblackphysicians.htm>. Another site provides the following information. “McDonough graduated from Lafayette College in Pennsylvania third in his class. He then studied medicine under an eminent professor of surgery at Columbia University and he later practiced at New York’s Ear and Eye Infirmary.” (*TangledWire*, Health Resources, The History Net, African American History, on the web at http://www.tangledwire.com/www/tangledwire/Twire/Afam/Backhistory/BH_Medicine.htm.)

¹¹¹ Meeting of 2 December 1929, Discussions of the Committee on Administration, College of Physicians and Surgeons of Columbia University, Special Collections, Augustus C. Long Health Sciences Library, Columbia University, New York, NY. Data and source from Ludmerer, p. 63 n22.

A little bit more is known about Columbia's stance in regard to post-graduate training of black physicians, as some foundations and groups have contacted the medical school in regard to this issue. In the mid-1930s, there was a series of contacts between the College of Physicians and Surgeons and the Rosenwald Fund. Among these was a 1935 inquiry whether Columbia might be able to arrange a one-year course of post-graduate clinical training for a colored physician whom the Fund was providing with a scholarship. The polite rejection which came from Columbia did not seem entirely predetermined and, in fact, some internal searching for a division into which a black physician could be placed for a year appeared to have been undertaken in earnest. The newly rebuilt Presbyterian Hospital, the School's principal teaching affiliate appeared to be ruled out from the start. The Associate Dean for Graduate Studies, Dr. Raymond B. Allen, then made a hopeful inquiry to the head of the Post-Graduate School and Hospital. The letter enthusiastically described Dr. Henderson's goal, the scholarship provided by the Fund, and ended with a statement from the author that he, personally, was "very much in sympathy with the efforts of the Rosenwald Fund and the problem of medical education of colored physicians generally."¹¹²

Alas, the inquiry received a two-part negative reply, typed right on the lower margin of the original letter. The first, and rather baffling part, was that "at Post-Graduate our ward service is too small to offer anything worth while to any physician for post-graduate study," while the second noted that "[a]s regards the feasibility of having a negro physician in the dispensary we went into that only recently and determined it was not possible to take on a negro physician." The routine seminar,

¹¹² Raymond B. Allen, M.D., Associate Dean, Graduate Studies, P&S to Dr. Herman O. Mosenthal, June 7, 1935.

without the clinical training, is all that could be offered.¹¹³ Apparently disappointed, Dr. Allen conveyed to Dean Rappleye that Dr. Mosenthal “[did] not feel that we have facilities as the Post-Graduate for a year’s training of this character for a colored physician.” He expressed his hope that “the time [would] come when facilities at Harlem Hospital [would] be available for educational purposes of this sort; it will certainly solve a great many of these problems.” On the margins, Dean Rappleye scribbled: “So do I.”¹¹⁴

In the end, then, the deans of the country’s best-endowed medical school, which had just relocated to a new joint campus with one of the finest private hospitals as its principal teaching affiliate, wrote to the representative of the Rosenwald Fund that “[w]e are very anxious to do everything we possibly can to help Negro physicians obtain additional training, but we find ourselves greatly handicapped at the moment because our present facilities at the Post-Graduate and at the Columbia-Presbyterian Medical Center are so limited.” Didactic course is all that Columbia could offer, although Dr. Allen also recommended that the Fund inquire about courses offered at the Mount Sinai Hospital.¹¹⁵ “I assure you that I understand your problems and have a corresponding appreciation for your willingness to help,” was the equally polite response from the Rosenwald Fund’s Dr. Bousfield.¹¹⁶

The placing of hope that Harlem Hospital might be able to take care of the glaring need for clinical and post-graduate education of black physicians in New York City was both fanciful and irresponsible and Columbia’s leaders undoubtedly knew it. Harlem’s troubled history of integration and its precarious financial situation were

¹¹³ Dr. Herman O. Mosenthal to Raymond B. Allen, M.D., Associate Dean, Graduate Studies, P&S, June 10, 1935.

¹¹⁴ R.B.A. [Raymond B. Allen], “Memo for Dr. Rappley,” June 11, 1935.

¹¹⁵ Raymond B. Allen, M.D., Associate Dean, Graduate Studies, P&S to Dr. M. O. Bousfield, M.D., Associate Director, Julius Rosenwald Fund, Chicago, June 19, 1935.

¹¹⁶ Bousfield to Allen, June 25, 1935.

indicative of inadequacy of such a solution.¹¹⁷ A municipal institution founded in 1887, Harlem Hospital was surrounded by the rapidly growing black community twenty years later. Like the rest of New York hospitals, whether private or municipal, it did not have a single African-American doctor on their staffs. By 1910, the hospital's patient census was fifty percent black. The overcrowding and the shortage of staff were constant problems and the reports of the mistreatment of Harlem's patients were rising. Nevertheless, when in 1917, Harlem Hospital hired several African-American nurses, many of the white nurses resigned. Even amidst one of the densest black communities, the struggle to introduce any African-American medical staff was going to be a hard one.

By 1920, over three quarters of the hospital's patients were black and the superintendent had finally agreed to take a colored doctor on to the Hospital's staff. Thus, Dr. Louis T. Wright was appointed clinical assistant in the Out-Patient Department, the lowest job possible at Harlem Hospital and his service there began on January 1, 1920. Four doctors resigned from the Hospital in protest and Dr. Casmo D. O'Neil, the superintendent and person directly responsible for Dr. Wright's appointment, was promptly demoted to the information booth at the Bellevue Hospital. Outraged at the racism shown by the hospital staff, the Harlem news media and community leaders mounted a campaign to remedy the situation and to gain staff access for other black medical personnel.

The first victory came in nursing. The establishment of the Harlem Hospital School of Nursing in 1923 represented a triumph by and for Harlem's black

¹¹⁷ I have relied primarily on the following two accounts of Harlem Hospital's history: "Harlem Hospital, Harlem 1900–1940," *The Schomburg Center for Research in Black Culture* (on the web at <http://www.si.umich.edu/CHICO/Harlem/text/hospital.html>) and "Clinical Medicine in Harlem," *The North By South: From Charleston to Harlem*, an NEH-sponsored project of the Kenyon College lead by the National Endowment for the Humanities Distinguished Teaching Professors of History Peter Rutkoff and William Scott (on the web at <http://northbysouth.kenyon.edu/1998/health/hospny.htm>.)

community. Until 1923, the only school in New York accepting black women for nurse training was the Lincoln Hospital School for Nurses in the Bronx, and as private school, it proved too costly for most. An alternative school was vitally needed. The first class of twenty students graduated in 1925, and all passed the New York State Board examination, qualifying as registered, licensed nurses. After the school was established, the hospital's white nursing staff was gradually phased out. As soon as the black students proved capable, they assumed patient care responsibilities as part of a work/study routine, and after graduation many returned to Harlem Hospital because they could find employment in only four municipal hospitals, Lincoln, Harlem and two special hospitals for tuberculosis patients.¹¹⁸

Over the next five years, unrelenting pressure by Dr. Wright, the North Harlem Medical Association, and the N.A.A.C.P brought results and, on November 23, 1925, the secretary of the Harlem Hospital medical board received official instructions that "as far as possible, all of the appointments to the house staff at the next examination should be colored men." In January 1926 three other African-American physicians were added to the visiting staff and Dr. Wright was elevated to the rank of assistant visiting physician. In 1929, out of the total number of sixty four physicians on the hospital staff, seven were African Americans. In the same year, Dr. Maynard was the first African-American intern officially appointed to the house-staff at the Hospital. Another appointment which marked a milestone was that of Dr. Peter Marshall Murray, who was appointed as a provisional assistant adjunct visiting gynecologist in 1929.

¹¹⁸ Though many civic leaders played a role in its creation, the primary credit belongs to Mr. William Vassalls and his daughter, Lurline Vassalls DeShields. When Lurline was denied access to the Bellevue Hospital School of Nursing because of her color, they spearheaded the drive for a school of equal quality at Harlem Hospital for black women. ("Clinical Medicine in Harlem," *The North By South: From Charleston to Harlem.*)

What to some appeared as a triumph of genuine racial integration, could have been also interpreted as a decision to make Harlem into a ‘colored’ institution of the City, removing the pressure to appoint black physicians at other city institutions. And that, apparently, was the implication with which Columbia was most comfortable. During this time, there were talks and correspondence between Columbia, the Rosenwald Fund, and members of New York’s black medical community regarding the possibility of affiliation between the College of Physicians and Surgeons and Harlem Hospital.¹¹⁹ The goal was ostensibly that of providing a quality post-graduate instruction to black medical graduates at Harlem but a part of the black professional community worried about “the difficulties and undesirable features of designating Harlem Hospital as a Negro institution, as this might imply official sanction to the principle of excluding colored patients and physicians forever from other city institutions.”¹²⁰ At the same time, an extended correspondence between the Dean of Columbia’s Medical School and the Julius Rosenwald Fund suggested that Columbia did not think much of the efforts within the black community to raise funds and establish separate private teaching hospitals where black physicians might receive clinical training.¹²¹ So what Columbia’s position really amounted to was a program of isolation of the City’s black physicians into one or a few municipal institutions

¹¹⁹ S.S. Goldwater, M.D., Commissioner, Department of Hospitals, City of New York, to Rappleye, February 26, 1934; Rappleye to Goldwater, February 28, 1934; Goldwater to Rappleye, March 1, 1934; Dr. M. O. Bousfield, President, National Medical Association, Chicago to Rappleye, March 23, 1934; Rappleye to Bousfield, March 26, 1934; C. Rufus Rorem, Associate, Julius Rosenwald Fund, Chicago to Willard C. Rappleye, Dean, College of Physicians and Surgeons, Columbia University, May 28, 1934; Rappleye to Rorem, June 7, 1935; Peyton F. Anderson, M.D., President, Central Harlem Medical Society to Rappleye, June 14, 1934; Rappleye to Anderson, September 27, 1934.

¹²⁰ C. Rufus Rorem, Associate, Julius Rosenwald Fund, Chicago to Willard C. Rappleye, Dean, College of Physicians and Surgeons, Columbia University, May 28, 1934.

¹²¹ Rappleye to Dr. Michael M. Davis, Julius Rosenwald Fund, Chicago, January 30, 1934; Davis to Rappleye, February 1, 1934; Rappleye to Davis, February 5, 1934; S.S. Goldwater, M.D., Commissioner, Department of Hospitals, City of New York, to Rappleye, February 26, 1934; Rappleye to Goldwater, February 28, 1934.

combined with the strengthening of the white professional control over the ‘colored’ institution.¹²²

After the war, the emerging allegations of discrimination against Jewish applicants have also propelled a look at the statistics on black students at New York’s medical schools. “Negro students are hardest hit by the discrimination against minorities in New York’s colleges” and “[t]he medical schools are the worse offenders,” declared the article in the *Daily Worker*.¹²³

Where the other minority groups, mainly Jewish and Italian students, who suffer discrimination are admitted on a quota system into the graduate and professional schools, the Negro finds the doors virtually barred.

The article reported that in the ten years between 1934 and 1944 “only 26 Negro students were enrolled in the four medical schools in New York County, according to data compiled by a County Medical Society investigating committee.” The paper interviewed the Deans of the Cornell and Columbia medical schools, marveling at their flat denials of discrimination. The outrageous fact was that “Cornell has not graduated a single Negro student” and its Dean “did not place any Negro students in the school until one year after the Medical Society began putting pressure on him to do so.” Thus, there was only one Negro student in the entire medical school, and one admitted for next year. The situation at Columbia was only marginally better. During the decade covered by the study, the College of Physicians and Surgeons enrolled only six Negro students and “of the six, four had been enrolled in 1941, the year of the probe.”¹²⁴

¹²² The affiliation did not take place as a result of a very complicated triangulation of interests and positions. It did eventually take place in the 1960s as a part of a larger political reform of the municipal hospital system which included its removal from direct political control and establishment of affiliations with private medical schools for all of the municipal institutions.

¹²³ “N.Y. Colleges Not Jimcrow – Just Don’t Admit Negroes,” *The Daily Worker*, March 25, 1946.

¹²⁴ *Ibid.*

The article said that, out of the 178 Negro physicians practicing in Manhattan, the majority were graduates of the two Negro schools – Howard University and Meharry Medical College, while 20 were graduates of foreign schools, concluding that it was “almost as easy for a Negro student to get on a boat and stay abroad for four years as it is for him to get into a medical school in this city.”¹²⁵

The paper reported that both Deans “admitted that the Negro students (or student) are faced with Jimcrow practices” which are “justified the same way southern lynchers alibi murder – the protection of white womanhood.” Apparently, the administrators of both schools admitted that “Negro students do not as a rule handle childbirth cases,” claiming it was “because the patients objected to being handled by Negroes.” The same also held for women’s diseases. Dr. Peter M. Murray, noted Negro surgeon and a visiting gynecologist and member of the Medical Board at Harlem Hospital, offered a rebuttal to this. He said that he saw hundreds women patients, both black and white, at the Hospital and in his private practice, adding that “[w]hite charity patients don’t offer any objections to any doctor.”

Charity patients’ objections are never needed in big hospitals. If they don’t like the treatment they are told that they can leave the hospital.¹²⁶

Thus, this kind of Jimcrow could only originate with the school, he said. This situation, noted the article, is all the more criminal when one remembers that the infant mortality rate and death from childbirth are by far the largest among the Negro population. Discrimination in medical school admission was, of course, part of the larger system of closed doors.

¹²⁵ *Ibid.*

¹²⁶ *Ibid.*

The few Negroes who do manage to break through the wall of discrimination in medical schools find it extremely difficult to get placed as interneers (sic) in private hospitals in the city. There has been some improvement in city hospitals in recent years, but nothing approaching the solution to the problem. The same is true with regard to placing Negro doctors on hospital staffs.¹²⁷

But the problem is apparent in undergraduate education as well.

One can walk the campus of Columbia University for days without seeing a Negro student. There are some – but Columbia has 23,000 students enrolled. Many Negro students don't even bother to apply, knowing that they do not stand a chance. They are forced, those who can afford it, to do far from their homes to Negro colleges to receive a higher education. These numbers were certainly sobering, given that there were at the end of the war, over 400,000 Negroes living in Manhattan alone.¹²⁸

The *New York Times* reported similar findings, although in a more understated form. The article appearing in March of 1947 quoted Dr. Viola W. Bernard speaking at the meeting of the NY Chapter of Physicians' Forum in the NYAM as saying that "[d]uring the 25 years between 1920 and 1945 fewer than 50 Negro physicians have been graduated from the 5 NYC medical schools."¹²⁹ The national figures were even more sobering.

The views of Columbia's administration on the issue of discrimination against African-Americans were predictably different, as evidenced by the letter addressed to the Chairman of the "Committee of 100," protesting the circulation of the article by Henry F. and Katharine Pringle entitled "The Color Line in Medicine" published in the *Saturday Evening Post*.¹³⁰

¹²⁷ *Ibid.*

¹²⁸ *Ibid.*

¹²⁹ "Few Negroes Listed in Medical Schools," *The New York Times*, March 14, 1947. That was, of course, the very same meeting to which Columbia's administration has sent one, or even two, spies.

¹³⁰ Aura E. Severinghaus, Associate Dean, College of Physicians and Surgeons to Bishop Francis J. McConnell, The Committee of 100, 20 West 40th Street, New York 18, NY, April 19, 1948. The first two paragraphs of the letter read as follows. "I am writing you because I notice that you are Chairman of the "Committee of 100." I am greatly disturbed to learn from Dr. Cochran, one of our loyal alumni, that in a recent communication to him from your Committee a reprint of the 'Pringle article' in the

In it, Columbia's Associate Dean, Dr. Aura E. Severinghaus proclaimed that

[i]f anyone is really interested in the facts regarding medical education for the negro or racial discrimination in general in the medical schools, and there is abundant evidence to show that neither the City Council Committee nor the Pringles were, these facts are readily available.¹³¹

The facts were summarized as follows.

There are many qualified applicants for medical school today who cannot gain admission because of the tremendous numbers who are now competing for admission. We have just completed the selection of our 1948 class of one hundred and fifteen from more than twenty-eight hundred applicants. Obviously many well-qualified applicants are among those whom we could not admit. In spite of this situation, I would venture nevertheless that any well-qualified negro applicant would gain admission just because he is a negro. I base this opinion on my own experience as the responsible officer of admission at the College of Physicians and Surgeons during the last six years. Well-qualified negro applicants are accepted by almost every school to which they apply. Of the last four negro students whom we accepted, three declined their places to go elsewhere, and two of these told me they had been accepted in every school to which they applied.¹³²

Dr. Severinghaus explained his letter as arising from a concern "about the false impressions which are being created regarding the negro in medicine." Where there was a real problem and a desperate need for action was "a program in secondary and college education which will produce competent applicants at the professional school level."¹³³

While loudly defending their right to collect information regarding applicants' and students' ethno-religious identity, in the context of the struggle over discrimination against Jewish and Italian students, Columbia feigned ignorance in

Saturday Evening Post was enclosed. As one who is constantly working toward the ends to which your Committee is dedicated, I feel that the circulation of this report, which amounts to its endorsement, does the cause of medical education and particularly negro medical education a great disservice."

¹³¹ *Ibid.*

¹³² *Ibid.*

¹³³ *Ibid.*

regard to the numbers of Negro students and staff. Actually, the degree of forthcoming differed with the inquirer. A 1949 letter from a physician at the Hospital Division of the Department of Public Welfare of the city of St. Louis received the following reply.

We have no hesitation in appointing Negroes but since we make no inquiries about race, we are not sure who are negroes and who are not. I have seen several around in different departments but I am sorry to say that we cannot give you any accurate information about either staff or students, as far as their nationality or color is concerned.¹³⁴

Two years later, an inquiry from the Dean of Meharry Medical College in regard to the number of Negro students enrolled at P&S was satisfied with full statistics: 4 in the first year class, 1 in the second, 2 in the third, and 1 in the fourth. In 1953, an inquiry by Charles F. Steward, Chairman of the Continuing Committee on Discrimination of the Medical Society of the County of New York, was replied to as follows:

In regard to Question 3, we have no way of knowing how many negro instructors we have on our teaching staff because we never asked the question. There are a few. We have quite a number of students who are apparently negro although we do not ask for his information when the student applies for admission. A report from one of the negro associations indicates that for the year 1950-1951 Columbia had as many negro medical students as any of the medical schools, excluding Meharry and Howard ... We are very happy to be high among the institutions helping in negro education.¹³⁵

Another thirteen years would pass before the College was able to reveal even an approximate numbers of African-Americans among its professional staff. An inquiry from Jasper F. Williams, M.D., Chairman, National Medical Association, Inc.,

¹³⁴ Rappleye to Dr. H. J. Erwin, Department of Public Welfare, Hospital Division, City of St. Louis, February 15, 1949.

¹³⁵ Rappleye to Charles F. Steward, Chairman, Continuing Committee on Discrimination, Medical Society of the County of New York, April 9, 1953, paragraphing removed.

Council on Medical Education and Hospitals, Howard University College of Medicine, was given the following reply:

We believe that there are approximately 25 Negro physicians on our academic staff. They rank from Assistants to Clinical Professors; some are full-time, other on our part-time teaching staffs. The departments involved include those of anesthesiology, dermatology, medicine, microbiology, neurology, ophthalmology, pediatrics, psychiatry, radiology, surgery and urology – and it is known that several have been on our faculty for decades and that others have passed their specialty board examinations.¹³⁶

The fuzziness of the numbers, the letter explained, was due to the fact that “it has been always our policy and tradition not to ask for or maintain records concerning all details of the backgrounds of our staff.” These approximate numbers became available “as a result of a recent survey requested by federal agencies.” These statements are hard to square with evidence of swift marshalling of similar information for internal purposes.¹³⁷ Only in the 1970s and later did the firm numbers become available as a result of the affirmative action reporting requirements.

The invisibility of the black students and staff also led to both the incomprehensible callousness toward their professional and personal needs and the collective effacement of their remarkable achievements and contributions. Margaret Lawrence, who was among the first black women to enroll at P&S, recalled that when she applied for an internship at Babies Hospital in 1940, she was turned down by Dr. Rustin McIntosh, chief of pediatrics. “He said he was pleased that I had applied ... that I was well qualified and they had hoped to accept me for internship. But since

¹³⁶ H. Houston Merritt, M.D., Dean, College of Physicians and Surgeons to Jasper F. Williams, M.D., Chairman, National Medical Association, Inc., Council on Medical Education and Hospitals, Howard University College of Medicine, September 7, 1966, paragraphing removed.

¹³⁷ The files, for instance, contained what seemed like a secretarial note (signed “10-7-46, ik”) to one of the College administrators which gave the following information: “Total Number Staff (excluding Nursing and School of Tropical Medicine) – 1,231; Number of Jewish staff members – 507; 41 per cent of staff is Jewish.” (Box 623, “Discrimination, 1946-1950s” Folder 623, “Newspaper Clippings.”)

there were no quarters for women interns at the doctors' residences, women interns had to stay at the [graduate] nurses' residence ... and the superintendent of nursing [Young] had said that they could not possibly accept Negroes in the nurses' residence."¹³⁸ A Class of 1940 nursing school graduate, Elizabeth Colmers Standen, remembered a more general sense of shock and disbelief at the extent of discrimination.

When I was at Presbyterian, I had a black friend, a doctor at Vanderbilt Clinic, who couldn't get his pregnant wife a private room. I went out of my mind. Here was this beautiful plaque in front of the Hospital, which read 'Without Regard to Race, Creed, or Color,' and it didn't admit blacks in the private pavilion, there were no black attending physicians, no black nurses, and no black nursing students. It was the times, I guess.¹³⁹

Even the best of the best among the African-American students and staff at Columbia were made invisible. It is hard to know the details of the reception and treatment which the few black students and associates received at the Medical Center but, if the official history of the institution is any indication, their presence and their work were made largely invisible. Between 1938 and 1941, Columbia had the honor of having Dr. Charles Drew enrolled in a program of graduate study at the Center on a Rockefeller grant. More importantly, Dr. Drew was centrally involved in the strategically very significant project of developing methods for creating stable blood supply in the face of the coming world war. Even though Dr. Lamb's book devotes the entire and separate section to the blood bank, considering it one of the most important projects in which the Medical Center was involved, its description of Dr. Drew's contribution is rather cryptic and gives him nowhere near the credit which most contemporary accounts suggest. Although it is Dr. Drew's name which now

¹³⁸ This account is from Goldberg, p. 225.

¹³⁹ Goldberg, p. 225.

graces the American Red Cross headquarters in Washington, D.C., Lamb gives far more credit to Dr. Scudder. Nor does Lamb mention the real reason for his eventual departure from the project – his outrage at the fact that, even in the emergency of war, the army and the Red Cross had a policy of the outright rejection of Black blood donors, later changed to the careful segregation of white and colored blood supplies. Dr. Drew's race, along with his outstanding career, was effaced as well. While Lamb's account of the blood bank project had much to say about the other early contributors to the development of the technique, including their nationality, nothing is said about why and how Dr. Drew came to be appointed to this strategically important undertaking, nor of his remarkable background.¹⁴⁰

¹⁴⁰ The following are the passages from the standard biography of Dr. Drew which pertain to his years at Columbia.

"In 1938, having accepted a two-year Rockefeller Fellowship, Drew continued his work in blood at Columbia University-Presbyterian Hospital in New York. Under the auspices of the Department of Surgery, he worked with Dr. John Scudder and Dr. E. H. L. Corwin on the problem of blood storage. Drew began to study the use of plasma as a substitute for whole blood. Because red blood cells contain the substance that determines blood type, their absence in plasma means that a match between donor and recipient is not necessary, which makes it ideal for emergencies. In 1939, while supervising a blood bank at Columbia Medical Center, Drew developed a method to process and preserve blood plasma so that it could be stored and shipped to great distances. (Dehydrated plasma could be reconstituted by adding water just before the transfusion.)

Drew graduated from Columbia University in 1940, with a Doctor of Science degree; he was the first African American to receive this degree. In his dissertation, "Banked Blood: A Study in Blood Preservation," Drew showed that liquid plasma lasted longer than whole blood. He was asked to be the medical supervisor on the "Blood for Britain" campaign, launched by the Blood Transfusion Betterment Association. At the height of World War II, Nazi warplanes were bombing British cities regularly and there was a desperate shortage of blood to treat the wounded. In order to meet the huge demand for plasma, Drew initiated the use of "bloodmobiles"—trucks equipped with refrigerators. The Red Cross has continued to use them during blood drives. In 1941 after the success of "Blood for Britain," Drew became director of the American Red Cross Blood Bank in New York. He was asked to organize a massive blood drive for the U.S. Army and Navy, consisting of 100,000 donors. However, when the military issued a directive to the Red Cross that blood be typed according to the race of the donor, and that African American donors be refused, Drew was incensed. He denounced the policy as unscientific, stating that there was no evidence to support the claim that blood type differed according to race. His statements were later confirmed by other scientists, and the government eventually allowed African American volunteers to donate blood, although it was still segregated. Ironically, in 1977 the American Red Cross headquarters in Washington, D.C., was renamed the Charles R. Drew Blood Center.

Drew was asked to resign from the project. He returned to Washington, D.C., and resumed teaching. In 1941 he was made professor of surgery at Howard University, where he had been rejected 13 years earlier, and chief surgeon at Freedmen's Hospital. In 1943 he became the first black surgeon to serve as an examiner on the American Board of Surgery. He was an inspiration and role model to his

Thus, the most shadowy existence in the practices of medical school admission and education was undoubtedly reserved for the African Americans.¹⁴¹ At Columbia, as in many northern schools, there has not been an official policy of exclusion. The miniscule number of black students who ever attended from, and even smaller number of those who graduated, compounded with utter lack of recognition of or recording of these facts, have rendered their invisibility very nearly equivalent to formal exclusion. The erasure of the very existence of the black students at P&S was probably deliberate. Until the 1960s, there was little positive that would come to the school from advertising the presence of a “colored” student and there may indeed have been many negative consequences wrought by the racially prejudiced. There was also no felt obligation on the part of the College to recruit and educate any more black students than were occasionally able to break through the combined obstacles of historical disadvantages, entrance requirements, hefty tuition and likely ostracism.

The Turning Point of the 1970s

The situation with the admissions of African-American and other racial minorities did not improve until the late 1960s. According to the recollections of the administrators and faculty at the time, the reasons for a change of policy had to do with mounting political pressure and institutional guilt, while the initial mechanisms of the change were an appointment of new admissions committee with a new

students and received numerous honorary degrees and awards during this period of his life, including the National Association for the Advancement of Colored People (NAACP) Spingarn Medal in 1944. He wrote numerous articles on blood for various scientific journals, and in 1946 was elected Fellow to the International College of Surgeons.” (on the web at http://www.galegroup.com/free_resources/bhm/bio/drew_c.htm)

¹⁴¹ Medical school statistics on Mexican-Americans, mainland Puerto Ricans, and Native Americans (the other groups designated by the AAMC in 1970 as “underrepresented minorities”) prior to 1971 do not exist, but their numbers were likely even fewer. [Kenneth M. Ludmerer, *Time to Heal: American Medical Education from the Turn of the Century to the Era of Managed Care* (London, Oxford University Press, 1999), p. 250.]

mandate.¹⁴² The political pressure of the civil rights movement and widespread urban rioting had a fundamental effect. As one member of the admissions committee recalled:

You couldn't pick up a paper any morning without being aware that places were having riots all over. I think everyone, more or less with one feeling, woke up to the fact that we have to make a bigger effort. There were many newspaper articles about it.¹⁴³

A faculty member recalled:

There was a sort of convulsion which was long overdue in the 68-69-70 period ... where the American public had to realize this was not a country club that could be run by one segment of the population while everybody else paid taxes.¹⁴⁴

The change in the structure and leadership of the admissions process provided an effective mechanism of immediate change. As the authors' of the student report explored the reasons for the change, they have found that "[f]rom most accounts, the admissions process ... pre-1970 ... was a 'one-man' show." A former administrator described the man who was in charge of the old admissions regime as follows:

He was conservative in his selection of students. He thought white males were what the medical school was about.¹⁴⁵

In contrast,

The first class admitted by the former dean's successor, Dr. Frederick Hofmann, was dramatically different. It was 20.4% female: almost 7% higher than the national average and nearly double that of the previous year. Dr. Hofmann's Admissions Committee is a more heterogeneous body which in

¹⁴² In 1970, new people have been appointed to a number of other key administrative positions, including the Dean of the medical school and the University Vice President for Health Affairs.

¹⁴³ "The Double Image," p. 6.

¹⁴⁴ *Ibid.*, p. 6.

¹⁴⁵ *Ibid.*, pp. 45-46.

fact operated as a committee. It is currently composed of 28 faculty members, 4 of whom are women and 4 of whom are black. In addition, 3 students sit on the committee and serve as observers. The changes in the population of P&S ... seem to indicate that a heterogeneous admissions committee is more likely to admit a heterogeneous student body.¹⁴⁶

Increase in student activism and protest played a part as well. Black students instigated the alumni recruitment effort for minority students during an alumni dinner in the late 1960s. A report on minority and women students, prepared in 1977, concluded that

[p]erhaps the single most important person involved in the change of admissions policies and procedures at P&S was Dr. George Lythcott, Associate Dean for Urban and Community Health Affairs from 1969 to 1974. Although his job description did not include responsibility for minority students, Dr. Lythcott became and remained involved in minority admissions and retention problems. When he was informed by the former admissions dean in 1969 that only 3 or 4 minority students had been accepted for the incoming class, Dr. Lythcott wrote a memorandum which has been held, by at least one administrator to have been of prime importance in the subsequent increase in the numbers of black students. In his memorandum, Dr. Lythcott decried the small number of black students at P&S and expressed extreme dissatisfaction with the schools feeble attempts to increase black representation. He stated that the situation was such that it was becoming increasingly difficult for him, in good conscience, to represent the institution.¹⁴⁷

Dr. Lythcott's concerns extended beyond the fact of admission but included the problem of retention as well. "After a minority students was admitted, Dr. Lythcott's office attempted to offer support, both academic and non-academic, to buffer the impact of an environemtn which was clearly alien to many of the students."¹⁴⁸ In the opinion of the Report's authors, the administration as a whole has been doing considerably less to make sure that recruited minority students successfully completed their studies and "the only measure implemented systematically by the P&S

¹⁴⁶ *Ibid.*, pp. 45-46.

¹⁴⁷ *Ibid.*, p. 7.

¹⁴⁸ *Ibid.*, p. 9.

administration and faculty to insure the retention of minority students was the passage of the automatic repeat regulations.”¹⁴⁹

By the late 1970s, however, there were signs of danger again, as the growth in the rate of minority enrollments have stalled or even rolled back. (See Table 5.3.).

Table 5.3. *Minority First-Year Medical School Enrollment at Columbia University and Nationwide, 1968-1976*

Year	Columbia		Nationwide	
	Number	Percent of total	Number	Percent of total
1968-1969	-	-	292	2.9
1969-1970	-	-	501	4.8
1970-1971	15	10.9	808	7.0
1971-1972	24	17.5	1063	8.6
1972-1973	25	17.0	1172	8.6
1973-1974	20	13.6	1301	9.2
1974-1975	14	9.5	1473	10.0
1975-1976	9	6.1	1391	9.2
1976-1977	8	5.4	1400	9.1

Source: “The Double Image: Women and Minority Students at P&S,” report prepared by Nancy A. Anderson, ’80 and Mary J. Roman, ’80, presented to Dr. Bernard D. Challenor, Associate Dean and Dr. Bernard Schoenberg, Associate Dean, October 1977, p. 9, Table 2, *Minority Group Enrollment in the First-Year Class: Nationwide and P&S*.

Probing into the factors which may have stopped the progress, the Report said that

perhaps the most important was a decline in recruitment ... directly attributed to the loss of Dr. Lythcott and the drop in Alumni Association funding. This decline also reflected changes in the national interest. The federal government has shifted its focus away from improving race relations through affirmative action in employment and education. Likewise, major foundations, responsible for much financial aid for recruitment, have developed other funding interests and priorities.¹⁵⁰

¹⁴⁹ *Ibid.*, p. 10.

¹⁵⁰ *Ibid.*, p. 15.

As one faculty member understood these signs to mean that there was not as much enthusiasm at the close of the decade, “primarily because the minority student had required proportionately more support, and financial support has become increasingly difficult.”¹⁵¹

Even as they entered in greater numbers, women and minority students occupied a different symbolic space, as well as a different structure of opportunity. Not everyone perceived these differences, but some did feel them with exquisite clarity, extending far beyond the experiences of personal slights.¹⁵²

Medicine is a male profession still (by and in large) so the sexism quotient is pretty high simply because there are a lot of men and few women. But that’s a kind of general attitude; bias specific to the field of medicine comes out in the clinical area most, I think. The small brushes we had with clinical encounters showed that. My feeling is that I was generally able to bear the offences toward women practised (sic) by faculty and male students. I don’t think I’ll be so able once the clinical year starts. Also the main feeling after one year isn’t just that medicine is sexist or racist or any other -ist, but rather that it just plain doesn’t care about the human beings as human beings and that is what is most enraging.¹⁵³

¹⁵¹ *Ibid.*, p. 15.

¹⁵² The following question was posed to women students: “Were there any problems you encountered during your first year in medical school which you feel arose solely because you are a woman?” Their responses were quite varied. Some recalled odd incidents, like being mistaken for nurses, being frequently touched by male professors, in a sort of fatherly, paternalistic manner. A female student working in the pathology lab for the summer recalled a number of times when people would assume they got a wrong number when she answered the phone in the lab – because there were not and have not been any pathology residents in years. Some did not think these were serious cases. One respondent said she had not encountered any gender-related problems “I suffered no problems of discrimination because of my womanhood. Basically I felt I was treated equally and well. I know women have a place in medicine or I wouldn’t be here. It would be helpful, however, to have more women role models so we can see what it would be like, so we can realize all the opportunities open to us.” Others, however, were on the opposite side of the pole. One woman answered as follows. “Women are clearly intruders in the medical profession, and this atmosphere pervades every aspect of life at school. Worst of all is the manner in which instructors and students deal with female patients. ‘Women’s consciousness’ has not yet hit P&S and this is an overwhelming problem. The atmosphere in class and in the hospital is often unbearable.” Another said that “[her] experience at medical school [could] only be likened to a foray into an enemy camp. The academic environment is dehumanizing and even Kafkaesque.” (“The Double Image.”)

¹⁵³ “The Double Image.”

Attitude – beginning with the sensitivity to the denigrating and dehumanizing practices – was also clearly playing a role in the kind of ‘social world’ into which these students were entering. Perhaps, as the story recounted by one of the students who participated in the survey for the 1977 Report on women and minorities testifies, both men and women, minority and majority students were apt to find themselves in the house of mirrors, unable to comprehend just what kind of profession they have chosen to enter.

When I was on Neurology, we had a patient, an old black woman, who had organic brain syndrome. She was very confused, her memory was gone, she wobbled on her feet, couldn’t stand up straight, and was very weak. We were trying to find a diagnosis for her. She also happened to have a large liver. We took this patient to Dr. ----, noted neurologist, well-known throughout the medical world, to get his advice, his tempered, seasoned advice, his experience in treating neurological disease. His major interest in the patient, after having heard her entire medical history, was not in helping us with the diagnosis, was not in helping us with what to do with this woman, how to help her and her family make the best of the situation, how to prepare her for what seemed probably death after a period of deterioration. None of these things. What he wanted to know and what he asked us in an offhand manner was, ‘What race has the worst drinking problems?’, referring to the woman’s large liver. Everyone was confused; people stumbled around a bit. We were all a bit aghast, but here was a noted, venerable figure. Here was what he wanted to talk to us about. The woman on my left stumbled forward and said, ‘The Irish,’ with nervous laughter. The resident behind her grabbed her arm and shook her playfully, saying, ‘You can’t say that about my race.’ She said, ‘but I’m Irish too.’ The resident then suggested, ‘Perhaps it’s the human race.’ Everyone was very relieved. But Dr.---- was not going to accept this. He repeated his question two or three times, looking at each of us, searching. Finally he said, ‘The colored race.’ We sort of reeled, looked at him, looked at each other, at the patient who was still there as he said all this. I sat there thinking: how could he have said all this, what should I do, should I make a big thing of it, should I get angry? If I don’t say anything, isn’t that being cowardly, not standing on my own convictions? Should I trust that everyone knows this man’s a looney? But I decided to say something. So I walked up to him and said, ‘Could you please give me your references for that?’, he being a man who has a reference in his hands at all times. He throws them out like seeds. He said, ‘References? I don’t need references. Everyone knows that.’ I now believe whenever anyone says ‘everyone knows that,’ there’s something wrong with the statement. I walked away and sat down next to a friend. He

came over and said, ‘Anyone who’s ever hired a colored person knows that.’ There was a black resident and he went over and asked him what he thought. The black resident was trying to hold onto his feelings and decided he was going to be cool and not talk about it. He finally said, ‘who introduced alcohol to the Indians? Who introduced alcohol to the Chinese? What race, in fact, has pushed alcohol all over the world?’ Dr. ---- had no answer to that, of course. The upshot of the story is that here’s a man who’s one of the leading figures at Columbia-Presbyterian, one of their sons, their laurels, and what is he doing but spreading racism, useless lies, and perhaps convincing someone. Hopefully they knew he was an old fool. But you can’t ever assume that the people who have prestige and power in the society, that their lies will not influence people. That’s the most blatant example I’ve seen recently, but it’s pervasive.¹⁵⁴

In the politically charged atmosphere of the 1970s, discomfort, disappointment, and shame at racist, sexist, and dehumanizing institutional practices were experienced by many different types of students, both from traditional and more recent pools of the medical students. Greater sensitivity was likely a characteristic of their generation, as well as specific backgrounds. If the cultural norm of the previous generation was denial or suppression of such experiences, the post-1970 students probably experienced more recognition, more anger, and more disappointment. As psychological studies of discrimination suggest, such experiences are apt to have significant consequences for subjects experiencing discrimination. Barring constructive outlets of anger and pain, they are likely to cause isolation, self-doubt and depression, often expressed in a “marked drop in energy and competence and increase in self-destructive behavior.”¹⁵⁵

It is not too difficult to venture that the psychological burdens imposed by insensitive institutional practices upon the ‘sensitive’ individuals created yet another structure of opportunity shaping their professional careers. This structure very likely

¹⁵⁴ *Ibid.*, p. 26.

¹⁵⁵ Quoted in “The Double Image” from Margaret A. Campbell, *Why Would a Girl Go into Medicine? Medical Education in the United States: A Guide for Women* (Old Westbury, N.Y.: Feminist Press, 1973).

retarded, as it were, those who could not overcome – by suppression or otherwise – the negative fallout of the experiences of injustice. Still mostly anecdotal, there is evidence that many socially sensitive individuals remain – by choice or by aversion – at the bottom of professional pyramids. There is also more firm evidence from psychological studies suggesting that the most distinguishing personal characteristic of those who have successfully climbed to the pinnacles of academic pyramids, is high levels of ... hostility. An indirect proof, perhaps, that the meek – in professional and academic fields – have a career structure of their own, one tending toward the bottom layers.

Still, many of the students fought back as evidenced by the formation of student organizations, the publication of the 1977 report, and other actions taken by the students. In a notable episode, six first-year women students objected to such comments in a letter to the Dean:

While humor is an invaluable asset, laughter at the expense of any group of people (Women, ethnic groups, patients, etc.) should not be justified or condoned. In particular, we feel that the same standards by which anti-semitic 'jokes' are judged to be in poor taste should be applied to 'jokes' made about women and female patients. Such humor creates an atmosphere scarcely conducive to the development of the respect and dignity which should comprise a physician-patient relationship.¹⁵⁶

The Dean was obliged to send the following communization to all department chairmen.

A number of students have come to the Office of the Dean during the past year to express their displeasure at Faculty humor and remarks which show a lack of respect for women students and women patients. This is a matter of great concern to me, as I am sure it will be to you. Therefore, I ask you to draw to

¹⁵⁶ "The Double Image." The report contained a number of more structural recommendations, including the formation of the Committee on the Status of Women, increased institutional support for the school's Black and Latino Student Organization (BALSO) and the institution of effective recruitment and remedial programs.

the attention of your faculty that such ill chosen remarks have an adverse effect on the whole student body. Thank you for your cooperation in this important matter.¹⁵⁷

The Report, which was issued nine months later, reported that the communication had an effect and asked the dean to “compliment the faculty on having decreased its volume of discriminatory remarks in response to his letter ... and stress that they continue to be vigilant in their efforts.”¹⁵⁸ The report did not shy away from incisive critiques of the school’s institutional practices and made a number of more structural recommendations, including the formation of the Committee on the Status of Women, increased institutional support for the school’s Black and Latino Student Organization (BALSO) and the institution of effective recruitment and remedial programs.

Still, for years afterward and most likely well into the present, women and minority students have been instructed by even the well-meaning mentors to play the games. At the 1986 conference on women in medicine the following advice was given by senior faculty women to their younger colleagues.

To advance in schools, everyone agreed, there is only one path: research. “You may be teaching,” Dr. Lewis said, “but there is no tenure, no promotion, no pay increase in the teaching component of your position; it is all in the research.” ... Other factors can help, however. “Get the best training possible, no matter what sacrifices you must make, and be board certified,” said Dr. Lois Anne Katz, associate chief of staff ... Along with training comes political game-playing. “It is important to know the right people and find them at your school,” Dr. Katz said. “Every medical school and every hospital has its own intricate political system.”¹⁵⁹

¹⁵⁷ Donald F. Tapley, Dean, to Dr. P. R. Srinivasan, Professor of Biochemistry, January 28, 1977. The note at the top of the page indicated that the copy of the same letter was sent to department chairman and institute director.

¹⁵⁸ “The Double Image.”

¹⁵⁹ The quote is from the proceedings of the conference “Women in Medicine: Challenges of the Future” held at Hunter College as reported in “For Female M.D.’s, Success at a Price,” *The New York Times*, April 16, 1986, p. C1.

At the 1991 AAMC Professional Development Seminar for Junior Faculty Women, Associate Dean of the Harvard Medical School offered the following five “laws” of successful academic medical careers in academic medicine, intended for men and women alike:

first, “If you don’t know where you’re going, any road will do”; second, “If you don’t play, you can’t win”; third, “A faculty appointment is only a hunting license – whatever you bag, you can keep”; fourth, “It’s not what you know but who you know”; fifth, “The playing field isn’t level – it’s tilted in favor of those who follow these rules.”¹⁶⁰

His take on the challenges and strategies specific to women was, if anything, even more disquieting. He counseled that “women need to pay careful attention to gaining appropriate credit for the work they do; second, women need mentors more than men do (but are less likely to find them); third, women have to either be twice as good as their male colleagues or work twice as hard to make sure their real worth finally registers.”¹⁶¹

Surely, nobody wants for underrepresented students to fail to succeed, yet there seems to be a profound lack of indignation that career structures are still shaped by ‘whom you know, not what you know’ and similar practices. There is a continuing assumption that students and junior faculty should just bow down and play to win – for their own sake, of course. When they make it, then they can be movers and shakers. Right now, we just need bigger numbers of successful women and minorities. If our goal is equal representation of every group, except those who might rock the boat too violently, than this policy is certainly right on target.

It might be instructive to revisit a different kind of advice on how to fight discrimination that was given to women a few decades ago:

¹⁶⁰ This account is adopted from More, *Restoring the Balance*, pp. 253-254.

¹⁶¹ More, *Restoring the Balance*, p. 254.

Constructive support can develop out of that anger in the presence of a sturdy sense of self esteem and the opportunity for frequent (if only brief) contacts with men and especially women who are committed to helping each other combat discrimination While the members of one's first small homogeneous group of mutual supporters often remain one's close friends, such 'consciousness-raising' groups often run their course and come to an end. Groups that coalesce with an action orientation – often concerned with social change not necessarily related directly to feminism – may provide some of the supportive contact. It is in fact difficult for a small homogeneous women's group to provide a sufficiently broad base of support to allow defusing of or constructive outlets for the anger. It is probably necessary, although perhaps not sufficient, to have the support of a network of women – and perhaps men – including some persons who are significantly different from one's self in class, occupation, and experience. This is, I believe, the meaning of 'sisterhood is powerful': that we work together to change discrimination against all women, not just our own small group. No individual woman can be liberated until all women, and all men, are liberated.¹⁶²

¹⁶² Quoted in "The Double Image" from Margaret A. Campbell, *Why Would a Girl Go into Medicine? Medical Education in the United States: A Guide for Women* (Old Westbury, N.Y.: Feminist Press, 1973).

CHAPTER 6

CONFRONTING LABOR: THE STRUGGLE FOR UNIONIZATION OF HEALTH CARE WORKERS, 1958-1976

Introduction

In the late 1950s, New York City became the center of an intense struggle over the right of employees in voluntary hospitals and health care institutions to organize and bargain collectively. Legally, the issue had long been decided in the negative: voluntary hospitals, as well as other non-profit organizations, were exempted from the landmark New Deal legislation establishing workers' rights to collective bargaining, minimum wages, and maximum hours of work.¹ While the legal ruling closely corresponded to the actual state of affairs in America's non-profit sector, in a handful of states, cities, and institutions, hospital employees were organized and worked under union contracts. These exceptions begged the question of whether the exemption of voluntary hospitals from the labor laws was an absolute necessity, as a matter of public policy, and whether allowing unionization in voluntary hospitals would be as disastrous as their spokesmen insisted.²

But the issue, of course, was not merely one of law, for hiding behind the legal exemption was a unified stand of hospital boards and associations against any concessions on workers' rights and any intrusions by the government in the hospitals' internal management. Individuals who sat on the boards of America's voluntary

¹ T.C. McKinney and M. Levine, "Legislation Governing Health Industrial Relations: USA" in *Industrial Relations and Health Services*, ed. Amarjit Singh Sethi and Stuart J. Dimmock (New York: St. Martin's Press, 1982).

² In the beginning of the unionization campaign in New York City, labor leaders specifically invoked Minnesota and, specifically the Mayo Clinic, and Hawaii as states where more enlightened thinking prevailed. ("Text of Statement by Hospital Union," *New York Times*, May 7, 1959.)

hospitals were not only members of the economic and political elite but also had a strong moral claim to social responsibility, public service, and concern for the welfare of the less fortunate. The ideal of the voluntary social provision, which supported their argument for exemption, was not a novel concept but a long-standing practice of unquestioning public support of private philanthropy. Hospital workers, on the other hand, were among some of the least powerful members of American society. Historically, hospitals drew heavily on immigrant, migrant, and surplus labor and were quite frequently the employers of last resort for unskilled, dislocated, and marginalized workers unable to secure any other jobs. With a high proportion of women, racial minorities, and recent immigrants, the hospital labor force was effectively isolated from the more powerful segments of American labor. It is not surprising, therefore, that, even during the high points of labor unrest, hospital workers have rarely risen in a clear demand for unionization, or that those who did were swiftly put down.³

As the 1950s were coming to a close, however, this state of affairs was about to change, first in New York City and then in other parts of the country. With the worst of McCarthyism mostly over, the more radical union organizers, who had been at the forefront of hospital organizing efforts prior to the ‘red purge’ and managed to survive those difficult years on the fringes of the labor movement, could breathe a collective sigh of relief and slowly start rebuilding their work. Of momentous significance to the future of New York’s hospital organizing was the tenacity of Elliott Godoff and the only hospital union contract he managed to win and maintain through these years. Godoff’s original, Communist-led union base had been destroyed in the fratricide of the McCarthy era. For a while, his efforts to find refuge for his tiny

³ Rosemary Stevens, *In Sickness and In Health: American Hospitals in the Twentieth Century* (Baltimore: Johns Hopkins University Press, 1989), pp. 164-166, 237; C. Schoen, “The Labour Movement in Health Care: USA” in *Industrial Relations and Health Services*, p. 57.

hospital chapter in a larger union were also repeatedly thwarted by the unions' indifference to hospital organizing and a systematic ousting and expulsion of organizers with past communist ties. Fortunately, in 1957 the pioneer of hospital organizing was welcomed into a small, but resourceful union of pharmacists and drugstore workers, Local 1199. The twenty-five year old union was led by a seasoned labor organizer Leon Davis who, like Godoff, had his roots in the radical wing of the American labor movement. The two unionists had in common so many details of their lives, it was surprising that their work had not brought them together decades earlier. When their paths finally did cross, however, the distinctive leadership and membership of 1199 was the perfect weapon to take on New York's arrogant hospital establishment.⁴

A broader foundation for change in hospital labor relations was emerging inside the hospitals themselves. The hospitals' and medical centers' robust growth during the post-war period, coupled with their growing cultural prestige as engines of scientific progress and social betterment, uncomfortably coexisted with persisting poverty among their lower-level workers. For most hospitals, the post-war period was also one of protracted transition from traditional-paternalist to modern-bureaucratic modes of management. This process was especially painful for the lower-echelon workers who were subjected to work restructuring, production speed-ups, stricter

⁴ The primary source on history of 1199 used here is Leon Fink and Brian Greenberg, *Upheaval in the Quiet Zone: A History of Hospital Workers' Union, Local 1199* (Urbana and Chicago: University of Illinois Press, 1989). For details of Godoff's and Davis' biographies, see pp. 17-21. On 1199's interracial membership and orientation, as well as its pronounced commitment to civil rights issues, see especially pp. 21, 24-25, 78-79, 102-103, 109-110, 112-115, 122-126, 184-186. For less sympathetic accounts of 1199's history and politics, see John Ehrenreich, "Local 1199: Where Is It Going?" *Health-Pac Bulletin*, July-August 1970, pp. 7-15; John Ehrenreich and Barbara Ehrenreich, "Hospital Workers: Class Conflicts in the Making" in *Organization of Health Workers and Labor Conflict*, ed. Samuel Wolfe (Farmingdale, NY: Baywood Publishing, 1978), "Hospital Workers: A Case Study in the New Working Class," *Monthly Review* 24, January 1973, pp. 12-27; Elinor Langer, "Inside the Hospital Workers' Union," in two parts, *New York Review of Books* 16 (May 20, 1971 and June 3, 1971).

discipline, and an erosion of formal and informal rights. The lower rungs of the hospital labor force were also increasingly marked by racial and gender segregation of women and minorities into the least-desirable, lowest-paid jobs.⁵

At the heart of the struggle to unionize hospital and health care workers was the plight of two segments of the American workforce. The first comprised the low-skilled, manual workers who ran food, laundry, housekeeping, and maintenance services. The second consisted of those semi-professional, technical, and clerical workers employed in the laboratories, X-ray departments, and record rooms of hospitals and medical schools. While there were some differences between geographic areas and individual institutions, the basic problem consisted of a common set of economic, social, and legal issues which placed these groups of workers at a considerable disadvantage relative to their employers, other hospital employees, and workers in other industries. In other words, even in a deliberately narrow view, the issues involved were broadly social and *not particular* to individual institutions.

As pressing as this simple conclusion might be to us or even to the impartial contemporary observers, this was not how the issue of hospital unionization was treated in the actual historical process. Although the struggle has prompted repeated political intervention and legal change, the conflict between the workers and the employers was systematically thrown back on individual institutions and organizations. Although the hospitals claimed that the “militant” labor movement had subjected them to *compulsory* unionism, this was an overstatement. While the law permitted unionization in the City’s voluntary hospitals, it did not make collective bargaining an automatic right of the workers. The legal presumption was, apparently,

⁵ Fink, *Upheaval*, pp. 2-6. In 1970, 80 percent of service and maintenance workers in New York City voluntary hospitals were racial minorities. (Municipal survey cited in Fink, *Upheaval*, p. 6, footnote 9.) Nationwide, women comprised 81 percent of hospital labor force. (Schoen, “The Labour Movement in Health Care: USA,” p. 57).

that the workers might have a reason not to want collective bargaining in their workplaces and that the decision should be left to several groups of employees within the individual institutions. But even the question itself – whether the workers wished to organize into a collective bargaining unit – was not, as a matter of law, to be raised on a systematic and comprehensive basis but only when a union organization claimed support of at least a third of employees in a particular institution or voting unit. Given the realities of highly disparate levels of financial, organizational and manpower resources available to hospital workers and their employers, it was clear that, what the law has actually given the workers was a right to vote for a union, when and if a union happened to choose their workplace for an organizing drive and managed to succeed in the face of predictable employer opposition.

Although undoubtedly a broad conflict over social and class structure, the bulk of the struggle for hospital unionization was destined to take the form of street warfare, fought institution by institution, voting unit by voting unit. It should, therefore, be entirely unsurprising that the main antagonists in this struggle appeared to be the hospitals and their lawyers, on one side, and the unions and *their* lawyers on the other side. Since the ‘enabling’ legislation established no self-actuating rights for the weaker social class, the struggle on behalf of the workers was going to be fought by organizations and through organizations. The strategy and tactics of particular institutions, as well as their union opponents, became important factors in the timing, sequence, and outcome of the struggle. The legally-codified institutional terrain of the struggle was itself a major determinant of its overall dynamic across the voluntary hospital sector.⁶

⁶ On the broader trends in the development of labor relations laws, see McKinney and Levine, “Legislation Governing Health Industrial Relations: USA.”

Nevertheless, even in the highly organizational and legalized context of the unionization struggle, the larger supra-organizational forces regularly intruded into the careful calculations of the warring sides. General structural-economic factors, familiar repertoires of cultural-ideological understandings, or particular situations of individuals and groups all marked the hospital unionization struggle as part of a larger social process. The relationship, in which these larger social (and class) factors stood toward the individual institutional contexts was not, however, that of the general to the particular. Although immanent in a broad economic domain, the larger social forces infused as much difference as commonality into the positions, identities and interests of the social actors involved.

The implication is that, like many other developments structuring health care politics, the story of hospital unionization cannot be understood without a dual analysis of institutional and class processes. Moreover, the finer details of the unionization struggle at Columbia-Presbyterian Medical Center explored in this chapter strongly suggest that the dynamics and outcomes of this political conflict cannot be understood with either the traditional class concepts or the non-class approaches that have vied to replace them. What is needed, I argue, is both a broader and more incisive view of social identity, structure, and action.

Learning from the Sidelines

Compared to other voluntary hospitals, Columbia-Presbyterian was in a fairly strong position to resist the union drive. As one of the largest and most prestigious hospitals in New York City, Presbyterian Hospital could well afford to pay its workers higher wages than smaller, less successful institutions. Although a dynamic and growing institution, Columbia-Presbyterian underwent its most dramatic institutional restructuring during the late 1930s, when the Medical Center was opened, and its lower-level employees experienced fewer disruptions in established work routines

during the postwar period than workers in other, later-developing institutions. No less importantly, it had a deep reserve of organizational will to resist the encroachment of the unionization. The kind of persons who served as trustees and officers of the oldest and most successful Protestant hospitals made Presbyterian into one of the least sympathetic institutions to the union cause.⁷

Early in 1958, when Local 1199's first victory at Montefiore Hospital in the Bronx signaled the beginning of a broad organizing drive in the voluntary hospitals, several unions vied for organizing Columbia-Presbyterian, the New York's largest institution with close to 1,900 workers. Shortly after the official kick-off of its campaign, 1199 assigned Phil Kamenkowitz, the union's regional director for the Bronx and Washington Heights, to conduct early morning leafleting at Columbia-Presbyterian. Without any contacts or connections on the inside, such a task was often a difficult one, especially at financially stronger institutions like Presbyterian where the workers were better paid and feared losing their jobs. Soon Local 1199 found that it had competitors on the Columbia-Presbyterian campus as Teamsters Local 237, State, County and Municipal Workers Union (now AFSCME) Local 302, and Building Service Employees International Union (now SUIU) Local 144 all jumped into the fray. Early in 1958, the Teamsters had reportedly reached an agreement with AFSCME, to keep 1199 out of Columbia-Presbyterian, one of the biggest plums in the newly open organizing field. Apparently, the strategy worked and 1199 withdrew organizers from Presbyterian to concentrate its efforts on those institutions where it had greater chances of success. At some point, AFSCME claimed majorities in five

⁷ The Presbyterian Hospital at Columbia-Presbyterian Medical Center, *Annual Report for 1950*, *Annual Report for 1955*; "Report of the President of Presbyterian Hospital for 1960," Columbia-Presbyterian Medical Center, *Combined Annual Report for 1960*. Unless otherwise noted, all information specific to Columbia-Presbyterian Medical Center has been obtained from the Health Sciences Division Archives and other materials housed at the Archives and Special Collections, Augustus C. Long Health Sciences Library, Columbia University, 701 W 168th Street, New York, NY.

hospitals, including Presbyterian but, unlike Local 1199, the public employees union did not push for a showdown of strength when it ran into a stonewall of resistance from Presbyterian's administration.⁸

Dealing with unions less determined to take the struggle to its logical conclusion, the Hospital's administration was content to wave the unions away, citing the voluntaries' exemption from the labor laws. When in April of 1958 District Council 37 of American Federation of State, County, and Municipal Employees demanded to be recognized as a collective bargaining agent of the maintenance department workers, Presbyterian responded to the union's lawyer with a brief letter which invoked the exemption of voluntary hospitals from the provisions of New York State and National Labor Relations Acts and stated the Hospital's unwillingness to recognize the union.⁹ Presbyterian's own maintenance employees, the majority of whom had allegedly signed union cards, worried the administration even less. Nearly six months after the event, Alvin J. Binkert, the Hospital's Executive Vice President of Presbyterian, issued a brief statement to the Hospital's maintenance employees. The document, which basically reproduced the Hospital's response to the union, cited no reason why these employees should not be able to bargain collectively other than the Hospital's legal right to deny it.¹⁰

⁸ "Three Hospital Unions Vie in Organizing," *New York Times*, March 17, 1959; "Threats of Strikes Mount at Hospitals," *New York Times*, March 18, 1959; Fink, *Upheaval*, pp. 45, 53.

⁹ Alvin J. Binkert, Executive Vice President, Presbyterian Hospital to "Our Maintenance Employees," October 3, 1958. Unless otherwise noted, all information pertaining to unionization at Presbyterian Hospital comes from the Health Sciences Division Archives, Dean's Code 281, Presbyterian Hospital; Presbyterian Hospital Committees, folders labeled "Union Activity," spanning the period from 1958 through 1976; all information pertaining to unionization at the College of Physicians and Surgeons, the medical school of Columbia University, comes from the Health Sciences Division Archives, Dean's Code 1, Columbia University: Misc. Topics/Senate, folders labeled "Union Activity at P&S," spanning the period from 1968 through 1976.

¹⁰ *Ibid.* The only extensive internal communication issued by Presbyterian at this time was addressed to the Hospital's supervisors, testifying to the degree of estrangement between the Hospital's trustees and administrators, on one hand, and the rank-and-file hospital employees. The message of the special "Bulletin for information of Supervisors" was to "reaffirm" to these employees "in important positions of trust and responsibility" why the Hospital holds to the policy of union non-recognition, "in

Ultimately, only Local 1199 had the chutzpah to call a strike vote and set the walk-out date in the six hospitals, where it focused its efforts, and Presbyterian was now fairly certain that its position in the coming struggle would be on the sidelines, rather than on center-court.¹¹ As one of the strongest among New York's hospitals, Presbyterian's primary role in the emerging conflict was to lend its organizational resources and social clout to the concerted efforts of member institutions to prevent or prevail in the strike. In the ensuing weeks, Presbyterian's trustees and officers, along with many of their colleagues from other unaffected hospitals, dutifully appeared at the numerous conferences and negotiation sessions arranged by the Mayor's office. Ostensibly, they were there to show solidarity with their sister-institutions and out of common concern over the issue of unionization. At the same time, their presence had a likely effect of "stiffening the backbone" of the six struck hospitals and the entire hospital association throughout the six-week long stand-off with 1199.

Representatives of the Catholic hospitals, who felt threatened by the much stronger financial position of both Protestant and Jewish hospitals, were among the most vehement opponents of any concessions, despite papal encyclicals on behalf of

accordance with law," and believes it to be "in the best interests of all directly concerned." The larger part of this communication argued that, despite its difficult financial position, the Hospital's workers received "good wages plus many extra benefits," which were listed in great detail. As to the Hospital's refusal to recognize the union, this position, argued the administration, did not stem from the "antagonism to unions as such" but was based "on the realistic view taken by Federal and New York State lawmakers who exempted voluntary non-profit hospitals from provisions of the labor laws." Both "responsible citizens" and even "some union organizations" know that "the collective bargaining of the commercial enterprise should not be transplanted to the hospital" where "[s]trikes, slowdowns, and work stoppages ... would be a matter of life and death." The letter concluded on a note which revealed the extent of the Hospital's institutional confidence and managerial paternalism. "Union recognition cannot gain for the employees, financially or otherwise, anything more than the Hospital intends to give them." The Bulletin warned that "union recognition would threaten the pioneering and service-minded spirit that has contributed so greatly to bringing the Hospital to its present outstanding position." This last point was undoubtedly calculated to strike a chord with those who saw their personal economic success closely connected with the fortunes and benevolence of the Hospital. Not incidentally, the copy of bulletin for supervisors was sent to Columbia-Presbyterian's professional staff, "for [their] information," of course. A.J. Binkert, Executive Vice President, Bulletin for information of Supervisors, The Presbyterian Hospital in the City of New York, February 6, 1959

¹¹ Fink, *Upheaval*, p. 56.

the workers rights to collective bargaining. Other hospitals, however, took positions which were not much more liberal. One labor leader, who took part in the negotiations, blamed the unaffected Protestant institutions like Columbia-Presbyterian and St. Luke's for hardening the position of the Greater New York Hospital Association and its president, who served as an official spokesman for the hospitals. A member of 1199, who was present at the talks, also saw these unaffected, prestigious, and mostly Protestant institutions as holding an effective suasion over the six beleaguered Jewish hospitals. Mt. Sinai's director Martin Steinberg recalled the vehemence, with which the Presbyterian trustee Sammy Schwarz (of the F.A.O. Schwarz toy empire) declared that he "would take apart Presbyterian brick by brick," if the union ever got there. Mayor Wagner himself stressed the influence of these wealthy spectators on the strike: "All through the negotiations there were observers from the other voluntary hospitals – New York Hospital, Columbia-Presbyterian, Roosevelt [and], boy, these fellows were really conservative! The struck hospitals were not acting on their own." Other observers, however, felt that the trustees of the struck Jewish hospitals needed no ideological encouragement from their gentile colleagues. According to one key negotiator for the strikers, the three most vicious hospital representatives were Jewish hospital trustees. Despite their liberal and even pro-labor reputations, these men had no sympathy for the working people when it came to their institutional fiefdoms.¹²

Just how important this group pressure was is hard to evaluate but, in the minds of many participants, the 1959 strike negotiations clearly indicated the ferocious resolve of the hospital elites to squash their enemies. Whether their intransigence arose from pressure by the other hospitals or from the instinctual

¹² The discussion in this paragraph is adopted from Fink, *Upheaval*, p. 82.

prejudice of their own boards and benefactors, the six hospitals refused to compromise at any point during the strike. Six-weeks after the walk-out began, the first multi-hospital union strike in New York City formally ended in a victory for the hospitals. The hospitals had not yielded an inch on the issue of union recognition and their only concession was a (surprise!) voluntary program of improvements, essentially identical to that offered before the strike ensued.¹³

Presbyterian Hospital, along with other unaffected institutions, came away from the City Hall with valuable lessons, both optimistic and cautionary. Throwing money and promises in the wake of strike threats appeared at least somewhat effective. First, hospitals with higher than average wage rates appeared more difficult to organize. Second, promises to increase wages and benefits seemed fairly effective in appeasing critics in the press. Such promises were ostensibly what the voluntary hospitals offered in lieu of being subjected to an independent fact-finding commission, a conciliatory deal they had unanimously rejected during pre-strike negotiations. Despite the fact that the promised improvements were, as Leon Davis put it, “a case of too little and too late” and “forthcoming only as a result of the union’s drive and the pressure of city officials and the press,” the mainstream press praised the hospitals’ program and concluded that, in view of such benevolence and good will, “Local 1199 will shoulder the responsibility far greater than the hospitals themselves,” if it proceeds with the strike.¹⁴

The hospitals were also forewarned of the union’s most explosive rhetorical weapon and the fact that 1199 would not hesitate to use it. The issue, of course, was

¹³ “A Program for the Improvement of Wages and Working Conditions of the Non-Professional Employees of Voluntary Non-Profit Hospitals of New York City,” *Statement by the Voluntary Non-Profit Hospitals of New York City*, May 5, 1959; Fink, *Upheaval*, pp. 84-90.

¹⁴ “Text of Statement by Hospital Union” and “The Hospital Crisis,” *New York Times*, May 7, 1959. For an assessment of the role of the press during the 1959 strike, see Fink, *Upheaval*, pp. 80-81

that of racial, as well as class, exploitation in New York's voluntary hospitals. As the New York Times reported, the race issue was raised at the City Hall meeting by Harry Van Arsdale Jr., president of the New York City Central Labor Council.

Mr. Van Arsdale said that the continued refusal of the six voluntary nonprofit hospitals to recognize the union would be a slap at "an abused minority." ... Benjamin J. Bittenwieser, chairman of the board of Lenox Hill Hospital, denounced the exploitation charge as "wild and irresponsible." As spokesman for the six struck hospitals, Mr. Bittenwieser said: "How ridiculous can you get? Our hospitals all operate at deficits. These deficits are accounted for mainly by the costs of rendering out-patient department services and maintaining in-patient wards which provide the only charitable hospital services to many thousands from the very groups we are accused of exploiting." But a union spokesman, Moe Foner, pressed the charge. "If these self-righteous philanthropists would stop exploiting thousands of Negro and Puerto Rican workers at \$23 and \$30 for a forty-hour week, their employees wouldn't need their charity. ... The truth is that the workers are the biggest philanthropists in the hospitals. They are striking to put an end to a system in which they are, in effect, subsidizing the hospitals through sweatshop wages that breed slums and disease."¹⁵

For decades, many thoughtful observers of hospital affairs had noted a disturbing "paradox that a charitable institution should tend to treat its employees in such a manner as to make them potential objects of charity." Local 1199, however, was the only union capable of effectuating a powerful and credible link between class and race exploitation.¹⁶ If the union's campaign would soon connect with the larger Civil Rights movement, its immediate answer to racial discrimination was class-based organization. "It is self-evident," wrote Davis in his statement days before the strike, "that the horrible conditions of work, the low wages, the lack of security and self-respect that these hospital workers endure today is due to the absence of a workers'

¹⁵ "Hospitals to seek contempt action on striking union," the New York Times, May 11, 1959.

¹⁶ The quote is from a report on work conditions in hospitals cited in Fink, *Upheaval*, p. 6. For a discussion of Local 1199's unique ability to combine labor movement and civil rights causes, see pp. 19-21, 24-25, 32-33, 78-79, 109-110, 112-115, 129-158 in the above.

organization among them. There is no other explanation or rationale for the substandard wages which are being paid to workers performing an essential service for the community.”¹⁷

Another cautionary lesson for the hospitals was the extent of support which the strikers and the union leading received from the labor movement, both in New York City and nationally. A crucial element in constructing labor solidarity was the early personal support of Harry Van Arsdale, president of New York City’s AFL-CIO Central Labor Council. From the beginning, the venerable labor chief had adopted the hospital’s fight as “our strike,” leading the Council to vote “food, money and moral support” to the hospital workers and working hard to secure co-operation of even the most conservative city unions.¹⁸ A total of 175 union locals officially voted aid to the hospital workers, sending a total of \$110,000 to the strikers in addition to truckloads of food and supplies. Several unions had “loaned” their organizers and held support rallies in front of the struck hospitals, while the members of a construction union, engaged in work for three of the six hospitals, walked out in solidarity with the hospital workers. In the words of the AFL-CIO regional director, Michael Mann, the hospital workers’ strike of 1959 provided “the finest display of labor unity in the City’s history.”¹⁹

¹⁷ “Statement by Leon J. Davis, president of Local 1199, Retail Drug Employees Union,” *New York Times*, May 7, 1959.

¹⁸ “Hospitals to seek contempt action on striking union,” *New York Times*, May 11, 1959; Fink, *Upheaval*, pp. 76-77. As Fink and Greenberg noted, Van Arsdale’s own public respectability and political connections aided immeasurably the hospital workers’ cause and the controversial union leading them. Early in the strike, Van Arsdale made sure the question of 1199’s past Communist ties, which alienated it from the mainstream of American labor movement, was effectively put to rest. In a dramatic demonstration of 1199’s acceptance, New York labor leaders secured a national endorsement of the hospital workers’ strike from the president of the AFL-CIO.

¹⁹ Fink, *Upheaval*, pp. 77-78; “Judge proposes hospitals truce to await ruling,” *New York Times*, May 14, 1959. In their official statements, the representatives of the hospitals were at pains to deny the extent of worker solidarity which emerged during the strike. Hospital spokesmen grossly overstated the number of workers who refused to walk-out – citing a number around 60 percent when in reality less than 10 percent refrained from participation in the strike. They even claimed that, among the volunteers who came to help the struck hospitals, were many “members of other unions ... incensed at a strike

On the upside, however, the hospitals could be fairly sure that, even if the strikers wanted to do so, they had rather limited capacity to disrupt the institutions' operation. To begin with, the Local 1199 walked a very fine line on this issue. On the one hand, the union insisted that the strike had the power to seriously disrupt the hospitals' operations and that the patients had to be transferred to other institutions. On the other hand, the strikers took pains not to cause any real medical crises, in part to preserve public sympathy for their cause. Before the walk-out, hospital workers made sure to leave their stations in working order and some even set up a telephone hotline to render assistance in case of emergency.²⁰ Before the strike began, the City's administration ascertained that, in the worst case scenario, public hospitals would be able to absorb most of the struck hospitals' charity patients and, if necessary, the Mayor could declare the state of emergency, with all its implications for the method of dealing with the strikers.²¹ Nothing so extreme, however, became necessary during the six weeks of the strike. Each hospital was able to count on the overtime effort of nursing and administrative staff as well as assistance of women's auxiliaries, spouses of the house staff, patients' relatives, both their regular volunteers and those who were moved to help for the first time during the strike. Although significantly understating their number of employees on strike, a week into the stand-off, the six affected institutions could justifiably claim that all service was "normal" and that they were "encountering no difficulties." Speaking for the voluntary hospital association, president of one of the struck hospitals had indeed declared that all its member institutions were "now prepared and confident they can cope without difficulty with

against the sick and suffering," a questionable assertion in view of the high level of labor solidarity with the hospital strike. ("Hospitals to Seek Contempt Action on Striking Union," *New York Times*, May 11, 1959).

²⁰ Fink, *Upheaval*, p. 71.

²¹ "Mayor Calls Union on Hospital Strike," *New York Times*, April 21, 1959.

any attempt on the part of the union to spread the strike to other hospitals.”²² More important than the army of volunteers in the long term was the ability of hospitals to hire new workers to replace the strikers. Offering hourly rates somewhat higher than those which obtained before the strike, the hospitals were able to start replacing a significant number of striking employees. Despite the overwhelming financial and human support from the other New York City unions, the strike was ultimately vulnerable to the structural effects of the army of surplus labor, the un- and under-employed New Yorkers who were willing to take the jobs despite the taunts and insults of the picketing strikers.

Managing the Legislative Process

Having avoided direct involvement in the 1959 strike crisis, Presbyterian Hospital emerged relatively unscathed and unchanged. The battle, of course, was far from over and the Hospital’s complex political strategy during the next several years revealed an intricate game played by an institution confident of its strength.

After a painfully inconclusive, if not altogether disheartening outcome of 1959’s long strike, the legal battle for the revocation of voluntary hospitals’ exemption from the labor laws emerged as a crucial goal for the leadership of the Union. Following several unsuccessful attempts to introduce the enabling legislation, the City’s labor leaders concluded that the only way to move forward was through the direct support of the Governor. During the spring of 1962, the union and its supporters finally succeeded in securing Governor Rockefeller’s support for the legislative amendment in exchange for an implicit promise of re-election support from labor and civil rights groups. After a series of behind-the-scenes communications, in June of 1962 a requisite atmosphere of crisis and public pressure ‘necessary’ for the

²² “Hospitals to Seek Contempt Action on Striking Union,” New York Times, May 11, 1959; “Judge Proposes Hospitals Truce to Await Ruling,” The New York Times, May 14, 1959.

Governor's intervention had been created and the settlement of the two-hospital strike was sealed with the Governor's official promise to introduce and push the enabling legislation.²³

During the period surrounding the negotiation, formulation and passage of the 1963 law Presbyterian played an intricate, three-sided game. Not wanting to be left out of the legislative process, Presbyterian, in association with New York Hospital, submitted a draft of legislative bill to the Governor, which accepted in principle the hospital workers' rights to collective bargaining. This initiative, apparently, has been undertaken with the approval of the Hospital's Board of Trustees but not with the knowledge of Columbia University, the Hospital's primary affiliate at the Medical Center. Learning of this proposal from other sources, Columbia's President, Grayson Kirk, was incensed that the University was not appraised of the bill and its "far reaching consequences for the University." Columbia's president was also puzzled by the Hospital's conduct, given that the Hospital Association of New York State, of which Presbyterian's Executive Vice President, Alvin J. Binkert, was President, released a statement strongly opposing such legislation.²⁴

The apparently contradictory stance of the Presbyterian's leadership was a result of divisions which had developed among the voluntary hospitals' administrative 'fraternity' since the start of the unionization drive. During the opening stages of the organizing campaign, first at Montefiore and then in six other hospitals, the issues were effectively confined to New York City and the Greater New York Hospital

²³ Fink, *Upheaval*, pp. 105-109.

²⁴ Correspondence: from Grayson Kirk, President of Columbia University to Augustus C. Long, Chairman of the Board of the Presbyterian Hospital, December 18, 1962; from A. J. Binkert, Executive Vice President, Presbyterian Hospital to Grayson Kirk, December 21, 1962, January 11 and 17, 1963; from Kirk to Binkert, January 17 and 28, 1963; "To the Honorable Members of the Legislature of the State of New York," A Statement of the Hospital Association of New York State, Inc. On Pending Labor Legislation, 1963.

Association (GNYHA) was the hospitals' main vehicle of collective action. After the six-week strike in 1959, some of the more powerful unaffected hospitals, including Columbia-Presbyterian, refused to sign the "Statement of Policy" pledging their participation in the permanent administrative committee on personnel policy, which was the sole and rather minimal concession to the workers' demands. Thus, while the city's voluntary hospitals had stood united in pressuring the struck hospitals to make no concessions, when it came time to share in the largely symbolic burdens of the strike settlement, the stronger unaffected institutions decided to free-ride.²⁵

When the Governor pledged to push for enabling legislation, the entire issue moved up to the state level, even though the organizing drives were effectively confined to the City. At this juncture, a new line of division among the voluntary hospitals in New York State had emerged. The *state* hospital association, while professing solidarity with its sister institutions in New York City, strongly opposed the legislation, effectively sacrificing the city hospitals in order to spare their own institutions. As President of the state hospital association, Binkert's name was the first under the group's statement opposing any legislation. As an Executive Vice President of Presbyterian Hospital, however, Binkert and some of his colleagues concluded that bare-knuckled opposition was not going to save the City's voluntary hospitals and was, therefore, quite eager to work with the Governor's office to write as favorable a bill as possible.²⁶

²⁵ Fink, *Upheaval*, p. 88.

²⁶ Columbia University adopted the official position of the Association of Colleges and Universities of the State of New York, outlined in "To the Governor and the Legislature of the State of New York, A Statement Urging the Retention of the Exemption of Non-Profit Educational Institutions from Collective Bargaining Provisions of the New York State Labor Relations Act, 1963." Kirk to Binkert, January 28, 1963 above; Grayson Kirk, President, Columbia University, "Memorandum to University Faculty Members (Columbia Corporation, Morningside Heights)," November 6, 1964.

There was, however, a third aspect to Presbyterian's game. The bill extending collective bargaining rights to the workers of the City's voluntary hospitals was signed by Governor Rockefeller on April 24 and was to take effect on July 1, 1963. Two weeks after the passage of the law, Presbyterian's administration issued an official communication to the Hospital's supervisors. Although occasioned by path-breaking legislation directly affecting the Hospital and its workers, the administration's statement was very similar to the "Bulletin" issued four year ago. In fact, most of the new document's text was actually simply reproduced from the old one, with few changes.

"As you have probably already read in the newspapers," began the open letter, "the New York State Legislature, in its 1963 Session, passed a bill which changes the legal position of collective organization and collective bargaining by hospital employees and the legal status of labor unions claiming to represent hospital employees." Neglecting to say what kind of changes they were, the statement proceeded to say that, "[i]n spite of these changes in the law, the basic policy of the Hospital with respect to attempts to organize hospital employees will not change." Emphatically, the Presbyterian's President declared that "[w]e have declined [union] recognition and continue to do so" Just as four years ago, the administration insisted that this position did not stem from "antagonism to unions as such." But whereas in a 1959 statement, the next sentence stated that the position was "based on the realistic view taken by Federal and New York State lawmakers who exempted voluntary non-profit hospitals from provisions of the labor laws," in 1963 the administration chose not to praise the wisdom of the legislators but only to say that their unchanging refusal to recognize unions reflected "a realistic judgment that the

policies and practices of trade unionism are unsuitable for a charitable hospital and are not beneficial to the Hospital, its patients or its employees.”²⁷

While wishing to have an input into the formulation of the bill, Presbyterian had no intention of honoring the new law. Although the legislation removed the exemption of the City’s voluntary hospitals from collective bargaining rights, the actual process by which the unions could be established at the hospitals was not obvious and allowed the hospitals to use a variety of legal and organizational tactics to fight unionization. With the legislation passed, the stronger institutions like Presbyterian could now concentrate on developing their anti-union strategy, without the burden of heightened public scrutiny, criticism, and pressure focused on the voluntary hospitals during the four years of the ‘illegal’ organizing drive. As might have been expected, the hospitals which had been involved in a six-week strike in 1959 were the first to be officially unionized. Although officially defeated, the workers at these hospitals were mobilized and unified by their unprecedented action and, with the Union’s support, continued to fight for unionization until 1963. With their bases secured in the original six hospitals, 1199 proceeded to organize the weaker or otherwise more promising institutions. In this process of ‘culling the weak from the herd,’ institutions like the Presbyterian or the New York Hospital once again found themselves in the least vulnerable positions.

The Battle Reaches Washington Heights

The experience of the non-profit sector during the fifties and sixties demonstrated that having at least one group of workers unionized dramatically increased the probability of organizing other groups within the same institution. The crucial step was ‘getting the foot in the door.’ In the case of Columbia-Presbyterian,

²⁷ A.J. Binkert, Executive Vice President, Presbyterian Hospital in the City of New York, “Bulletin for information of Supervisors,” Number 8, May 23, 1963.

there were actually three institutional doors through which the unionization could be brought in: the Hospital, the Medical School, and Columbia University proper, located fifty blocks to the south of the Medical Center. And Columbia University proved to be the weakest link. Despite the determinate struggle to keep the unions out of the University dining halls, in 1968 Local 1199 won the right to represent cafeteria workers. This was 1199's first contract at Columbia and waves of fear quickly reached the Medical School whose officers justifiably feared that they might be next on the Union's agenda.

On August 1, 1968, School officials met with their attorneys to discuss the situation at the Morningside campus and develop a common strategy. According to the confidential memorandum, the attorneys "expressed unhappiness [of the Columbia's administration] that 1199 won the election over the Transport Workers Union with respect to the cafeteria employees." In their opinion, "1199 [was] an utterly ruthless outfit" and would "go to great lengths - student involvement, etc.," and was now "on the crest of the wave as a result of their recent contract victory with the hospitals." The lawyers unanimously felt that "1199 will go to any necessary lengths to get into P. & S. and this will be a stepping stone to a juicier plum - Presbyterian Hospital." The lawyers were authorized to inform the Medical School that, in view of the recent events, "the University's policy downtown is to attempt to keep 1199 out of other areas by encouraging 153 (office workers) to get in ahead of them." The office workers union had "a good reputation and [Columbia] would be in a much better position if they were successful rather than 1199." With the approval of the central administration, the lawyers recommended that the Medical School to encourage Local 153 to beat out 1199 in organizing the non-professional workers. Encouraging a rival union was, of course, "no guarantee" of the desired outcome. It was clear that 1199 would inevitably "make things hot up here - pickets, demonstrations, student

participation (SDS, they say, is actively involved)” and that the School’s “support for 153 will certainly not be taken lying down by 1199 who will charge that we are bringing in a company union, negotiating a ‘sweetheart contract’, etc.”²⁸

While acknowledging the reasoning behind the strategy adopted at the downtown campus, P&S officials hoped that the situation at the Medical Center was not “yet at the point where we should move actively to bring in 153, with all the implications of that step.” If P&S adopted the strategy recommended by the University administration, the Presbyterian Hospital “would certainly be most unhappy as might be a good many of our people who want no part of unionization.” Not long before, the College and the University’s labor lawyers had initiated a “study on comparative wage and benefit scales” and a “survey of opinion by the administrative assistants” and the Medical School decided to refrain from any action until the results of the wage survey and “a valid reading of [the administrative employees] present sentiments” were completed, which would be in a few days.²⁹

As the University’s lawyers warned, an organizing drive for Local 1199 was soon underway at the Medical School. Following its strategy in other organizing campaigns, the union relied on the institutions’ current employees to initiate and develop the organizing drive. Whether the union initiated the contact with the institution or a group of interested employees contacted the union first was immaterial because without genuine interest and active participation on the part of at least a small group of employees, the Union’s organizing staff could not hope to mount a successful organizing campaign. At Columbia’s College of Physicians and Surgeons, the

²⁸ Douglas S. Damrosch, M.D., Assistant Dean, College of Physicians & Surgeons of Columbia University, “Memorandum to Dean Merritt,” August 2, 1968.

²⁹ *Ibid.*

unionizing drive began in the Fall of 1968, led by a ten-person group of employees forming a “P&S Organizing Committee of Union Local 1199.”³⁰

While the Union’s campaign in New York’s hospitals seemed almost unstoppable, medical schools did constitute a new organizing terrain with its own peculiar set of challenges. Reaching medical school employees with the union message was not an easy task. Union organizers were almost overwhelmed by the number of different services and floors they had to cover in order to make contact with hospital service workers and top medical schools like Columbia were even more complex than the hospitals. Whereas Presbyterian had only one teaching affiliate, the Columbia University’s Faculty of Medicine consisted of the schools of medicine, nursing and public health. The Medical School also had many other hospital affiliations besides its primary base at the Presbyterian Hospital. In addition to several public hospitals located near the Medical Center, such as the state-owned Neurological Institute and the Delafield Hospital specializing in cancer, P&S also had professional appointments and some semi- and non-professional staff in a dozen other public and private hospitals in the metropolitan area. The School also ran several specialized operations such as laboratories, animal care department, dormitories, library, and the like. Finally, the Medical School still served as an umbrella organization for both the School of Public Health and the School of Nursing and, from the outset, the organizing drive included the former under the general ‘medical school’ operation.

The considerable autonomy and isolation of the separate departments of the Medical Center meant that medical school employees, whom the 1199 organizing campaign was trying to reach, had little contact with workers outside of their

³⁰ Letter from Karen Kartlie, Technician, Neurological Institute, 11th Floor on behalf of the P&S Organizing Committee on Union Local 1199 to H. Houston Merritt, Dean, College of Physicians and Surgeons of Columbia University, November 15, 1968.

departments. In fact, the employees had considerably far more contact with their supervisors, medical school faculty, and administrators within their respective departments than they did with workers in other parts of the school. The potential difficulty of organizing this segmented labor force was well illustrated by the departmental affiliations of the thirteen or so members of the original Organizing Committee for Local 1199 at P&S. Two of the committee members were employees in the School of Public Health, another two came from the Department of Neurology, while the remaining nine were from Physiology, Neurophysiology, Microbiology, Pediatrics, Pathology, Animal Care, Obstetrics & Gynecology, plus Microbiology and Clinical Pathology at the Delafield Hospital. Some of them indicated the floor number in the hospital building where they worked to be more precise about their location in the School's complicated organization.³¹

In strategic and ideological terms, medical school employees were a substantially different social group from the hospital workers. In contrast to 1199's successful hospital campaign which mainly involved mostly unskilled workers, medical school organizing involved predominantly semi-professional, technical, and clerical employees. At P&S over eighty-five percent of the employees were classified as technical or clerical, with fewer than 15 percent falling into the 'service worker' category. Even compared to the University's undergraduate division, the medical school had less need for dormitory, dining, and maintenance services and, therefore, a much smaller proportion of unskilled and low-skilled employees.

Despite its origins as a white-collar pharmacists' union, 1199 had previously focused almost exclusively on the non-professional workers and thus the Union had

³¹ *Ibid.*

little experience with white-collar workers outside of its original pharmacy wing.³² Although there were many indications of interest in unionization and in 1199 in particular among the City's and other semi-professional medical school and hospital workers, the Union's leadership did not rate the chances of success among these employees as very high and channeled few resources into it. The white-collar employees, they felt, were on the whole unprepared for the militant struggle which the Union was conducting in the late fifties and early sixties.

Legalization of collective bargaining rights in the City's hospitals improved somewhat the prospects for white-collar unionization and 1199 was hoping to expand its efforts in this area. As early as 1962, however, there was a feeling that in hospitals and medical centers it would not be possible to "just put workers together regardless of their background and station in life, in their job and how they make a living." Receiving reports from a few of their semi-professional members that their co-workers wanted "an organization *of professional employees for professional employees*," the union leadership moved to create separate divisions for non-professional and white-collar workers. The restructuring was also prompted by growing discontent within the union's oldest constituent group – pharmacy workers – who felt overshadowed and neglected by the union's consistent focus on hospital organizing. Conceding that there probably was not and might never be complete identity of interests between pharmacists and non-professional hospital workers, the union was reorganized as three separate divisions: one for drugstore employees, another for non-professional hospital workers, and the third for semi-professional and technical hospital employees.

This last division was officially named the "Guild of Professional, Technical, Office, and Clerical Hospital Employees." Jesse Olson, a former registered

³² The following discussion of Local 1199's involvement in white-collar organizing is adopted from Fink, *Upheaval*, pp. 116-119.

pharmacist and Local 1199's organizer since 1959, was elected to head the Guild and, like the other two union divisions, it was to keep its own records, collect its own dues, and create its own delegate assembly.³³ The Guild began with about 500 members, mostly comprised of technical and semi-professional workers at Montefiore and Maimonides hospitals, as well as a few at Mount Sinai and Beth Israel. Guild organizing proceeded considerably slower than that among the non-professional hospital workers, with the highest rate of success in institutions where 1199 already represented the latter. A major breakthrough occurred in 1967, when, for the first time in the union's history, it won representation of employees in a medical school, the Albert Einstein College of Medicine.

Despite the Union's success at Einstein, many questions of strategy and tactics in this new terrain remained unresolved. At Einstein, for instance, 1199 did not have to organize the union from ground up but took over the independent employees organization which had been formed one year previously but made little headway in terms of effective bargaining with administration. Thus, the victory at Einstein had to be attributed in part to the administration's strategic error of stonewalling the original, 'in-house' employee organization. Thus, this victory did not necessarily portend success in convincing other semi-professional employees to affiliate with a large, mostly non-professional, and militant union like 1199.

Reflecting the union's strategic and programmatic ambivalence about its new divisional structure, the early organizing drive at P&S did not clearly communicate the

³³ Although 1199 used the term "professional" in its official designation of this category of employees, throughout the chapter I use the term 'semi-professional' or 'lower professional' to distinguish these employees from the 'higher' or 'full' professionals like physicians and surgeons. 'Professional,' of course, was and continues to be a highly contested and sensitive term, claimed by a wide variety of occupations, including nurses, administrators, mechanics, etc., for different purposes and in different conjunctures. It appears that in the case of 1199, the term "professional" was actually dropped from the official name of the Guild division around 1975. For a more detailed discussion of 'professionalism,' see Chapter 4.

identity of the employees which the Committee for Local 1199 tried to organize and, by extension, their 'place' within the organizational and governing structure of the large and rapidly growing union. Most written communications issued by the Organizing Committee to P&S employees omitted any reference to the 'Guild,' the union's separate division for the semi-professional, clerical, and technical workers. Sometimes, but not always, 1199 was identified as the Drug and Hospital Union. Some of the union cards, which the organizers tried to have employees sign, suggested a very precise and narrow definition of the union group which the workers were invited to join. Across the top of the cards, in large capital letters, was written "Guild of Professional & Technical Hospital Employees" and underneath it was an even finer focused designation: "Medical and Scientific Research Department." This designation omitted, for some reason, the 'office' and 'clerical' workers, although the discussion drafts of the proposed union program, circulated by the Organizing Committee, included secretaries and other office workers as one of the targeted employee categories.³⁴ Amidst the wide variety of terms and categories, it was unclear how the various groups of employees fit into the union's overall benefit and governing structure and how the union would serve the potentially very different interests of these disparate groups. As with so many other instances of economic and class struggle, the organizers' fundamental problem was the articulation of the 'community of interest.'

Unfortunately for 1199 and its supporters, the Union's rival in the P&S organizing struggle had no such burden. Although the University's labor lawyers urged P&S to encourage a more mainstream organization, like the office workers union's Local 153, to get in ahead of 1199, an even better alternative became available

³⁴ Assorted leaflets, circulars and correspondence by the P&S Organizing Committee of Local 1199.

in due time. A month or two after the 1199's Organizing Committee announced itself to the school's administration with a request to use University meeting facilities, a professionally composed communication from the "Supporting Staff Association of the College of Physicians and Surgeons of Columbia University" was circulated among employees, inviting them to attend the organization's meeting. While the details of Association's founding were unclear, the organization was soon able to hold meetings on Medical Center's premises and Otto Gonzalez, a research worker at the School, emerged as the Association's Temporary Chairman.³⁵

Unlike 1199, which exhibited difficulty defining their structure and targeting worker groups, the SSA had a very straightforward definition of its membership: "[a]ll employees of the College of Physicians and Surgeons who are paid semi-monthly." The name of the College and its parent University were actually included in the Association's official name, arousing no protestations from the administration. This deceptively simple 'community of interest' promised an uncomplicated structure for "discussion of improvements salaries, pension, medical benefits, etc.," as Association defined its purpose: one discrete institution, one discrete group of employees, one administration to deal with.³⁶

The Union's Strategy

In some respects, 1199's organizing strategy at P&S was very similar to that it used at the hospitals: develop a group of inside supporters and turn day-to-day activity over to them; look for workers' issues, large and small, and address them in a dramatic, powerful form; organize meetings, write petitions, and involve the rank-and-

³⁵ Supporting Staff Association of the College of Physicians and Surgeons of Columbia University [hereafter SSA], untitled statement of purpose, prospectus and meeting announcement, undated (likely February 1969). Otto Gonzalez, Temporary Chairman, Supporting Staff Association of the College of Physicians and Surgeons of Columbia University, open letter and activity report, undated; untitled four-page outline of proposed changes in employee compensation, benefits, and procedure, undated.

³⁶ *Ibid.*

file as much as possible; and thus create through constant activity and worker involvement, a tangible and positive presence for the union.³⁷ From another angle, however, the Union was treading on a terrain much different from its hospital organizing drives and had to develop a different approach. The groups of employees targeted in this campaign were not only different in their socio-economic, racial, and gender composition but were also engaged in a different set of structural relations with their employers, superiors, and other workers.

The key difference between non-professional hospital workers and the semi-professional medical school employees was their relationship to the professionals within their respective organizations and, more generally, to the system of credential-based division of labor. With few exceptions, the non-professional hospital workers had little contact with the highly credentialed, professional people working in the same hospitals. Kitchen, laundry, and maintenance employees were truly ‘invisible workers,’ whose contacts with others in the organization were mostly limited to their immediate supervisors. In contrast, the semi-professional medical school employees worked much more closely with both professional employees and the administration. Assigned to particular academic departments, or even to individual doctors and researchers, these various assistants and technicians were more similar, in both personal and structural-economic terms, to their superiors. Their hiring, assignment, and promotion, as well as much of their work routine, depended on the personal dispositions of their superiors. The security of their employment and prospects of advancement also depended on the continuation of outside, competitive grants made to a particular investigator, project, or department. In addition, the semi-professional workers were more likely to have had contact with the institution’s administrative

³⁷ Fink, *Upheaval*, p. 190.

officers and one particular group among them, secretaries and office clerks, stood in an especially close, sometimes highly personal relationship to the administrators. Not only did these employees work within more clearly defined ladders of job advancement, but their educational credentials – whether a high school diploma or a bachelor's degree – held open a prospect, however modest, that they might join the ranks of professionals themselves, via graduate education.

Although the union relied on a simple dichotomy between the workers and the administration when organizing and representing non-professional employees, such a reductive analysis was impossible with semi-professional medical school employees. The rhetorical strategy of the P&S Organizing Committee slowly emerged during the early months of communications with the administration and fellow employees. One of the earliest 'clarifications' of the 1199's position came through in a confrontation over the use of the university meeting facilities. On November 15, 1968, Karen Kartlie, a technician from the 11th Floor of the Neurological Institute, wrote to Dean Merritt with a request to use the University's Alumni Auditorium for an employees' meeting. Informing the Dean that, over the past few months, the activities of the Organizing Committee have grown, Ms. Kartlie wrote that the "committee of employees [felt] that future meetings should be held in a central University building convenient to all employees of the College." Replying for Dean Merritt in his absence, Assistant Dean Douglas Damrosch wrote that it was a "University-wide policy and, for that matter, accepted practice elsewhere, that University premises are not to be used in this manner." As a further reason for the denial of the Organizing Committee's request, Assistant Dean noted that the State Labor Relations Board

prohibited employer institutions from allowing the use of their facilities to the contending organizations in advance of a union election.³⁸

In ensuing correspondence and tense meetings with the administration, the Organizing Committee developed a coherent posture with respect to the rights and interests of the employees it endeavored to organize. After contacting both the National and the State Labor Relations Boards, the Committee rejected the administration's 'legal' reason for denying the use of University meeting facilities. "It seems to us," stated the Committee, "that the question is one not of law or regulation but the nature of the university." Citing the report of the Cox Commission, which had studied the campus disturbances at Columbia University in the spring of 1963, the Committee underscored that "[a]ny tendency to treat a university as a business enterprise faculty as employees and students as customers diminish vitality and communal cohesion." The medical school employees, argued the petitioners, were as integral and vital part of the University as any other group and should be accorded the same rights. As one of these rights, argued the Organizing Committee,

the use of university facilities by any constituent unit of the university should, within the bounds of respect for the rights of other constituent groups, be recognized as a right to be employed responsibly and discretely in the interests of members concerned. The administration's prerogative to grant permission for the use of such facilities should, we believe, be regarded as a function of traffic control rather than of the dispensation of privileges.

Noting that, in recent months, the auditorium had been used with University consent by diverse groups (including the Medical Committee for Human Rights and the Health Professions for McCarthy), the Committee concluded that the denial of its request must stem for the administration's deliberate attempt to "thwart employees in

³⁸ Karen Kartlie to Dean Merrit, November 11, 1969; Douglas J. Damrosch, Assistant Dean to Karen Kartlie, November 19, 1968

establishing a legitimate organization to represent them in employment negotiations.” The petitioners concluded with a hope that the administration would reconsider its position in order that “what is in fact a rather routine administrative matter can be resolved amicably.” This would be fully consistent with the spirit of the organizing efforts which aimed, after all, not at the antagonism with the administration but at creating “a viable and dynamic instrument of employee representation.”³⁹

This time the letter was signed, in addition to Ms. Kartlie, by ten other members of the Organizing Committee, and Dean Merritt quickly contacted University’s labor attorney for advice on how to handle it. The labor counsel furnished Dean’s office with a response whose basic point was that it “was not the policy of the University to assist any union seeking to organized a group of employees by providing it with University facilities to speak to our employees.” The letter suggested that Local 1199 should do what it has done in the past, namely, secure non-University facilities to deliver “whatever message [it] would to the employees.”⁴⁰

Having gotten nowhere through correspondence, the Organizing Committee requested a meeting with the Dean. After some evasive tactics on the part of the Dean’s office, on December 27, 1968 about sixty employees came to the meeting with Dean Merritt and Assistant Dean Damrosch to discuss the use of the University’s meeting facilities. The employees’ main message was that, in rejecting their prior requests, the administration denied the rights of their *employees*, rather than of the Union Local 1199. “We are organizing *ourselves*,” “*we* asked 1199 for help,” and “we are *not* being organized from ‘outside’” were the petitioners’ arguments. Though the meeting was peaceful, the Dean pulled a familiar bureaucratic tactic of sending the

³⁹ Karen Kartlie to Dean Merritt, December 2, 1968.

⁴⁰ Secretary’s (?) note to Dean Merritt, December 4, 1968: “Mr. Nye and Mr. Paranda recommend that you send the attached reply to Miss Kartlie.” Merritt to Kartlie, December 4, 1968.

petitioner one level up and suggested that the employees take their request to the central university administration at the Morningside campus. He even offered to review the draft and make comments and criticisms. After two more months of delays and denials, Dean Merritt finally informed the Committee that, effective April 1, 1969, “Section 704 of the State Labor Relations Law will apply to all educational institutions” and will make it “illegal for an employer to interfere with the formation, existence or administration of any employee organization, union or association by any means,” including “donating free services, equipment, materials, office or meeting space or anything else of value.” He then invited the Committee to go ahead and make any meeting space requests in the remaining two weeks before the law came into effect.⁴¹

It was clear that the school’s administration was doing all it can to paint the activities of the Organizing Committee as impositions of the ‘outside’ union upon ‘their,’ i.e. College’s, employees. The Committee had to go to great lengths to assert that the initiative came from ‘inside’ the College, that the organizing was initiated by the employees themselves. Indeed, in one of the letters to Dean Merritt, the Committee pointed out that one of the main reasons why P&S employees “requested” the help of 1199 was “the autonomy in policy and direction it accords its constituent groups.”⁴² Nevertheless, the ultimate struggle for unionization, as 1199’s veterans organizers undoubtedly knew, was going to be waged in the hearts and minds of the employees, rather than in the Dean’s office. And here, convincing the semi-

⁴¹ Two notes from MJS [secretary ?] to Merritt regarding telephone conversations with Karen Kartlie. P&S Organizing Committee of Local 1199, “A Report of Meeting Between Dean Merritt and the Union,” undated. Robin Elliott, Interim Chairman, P&S Organizing Committee to Merritt, March 3, 1969. Merritt to Elliott, March 14, 1969.

⁴² Elliott to Merritt, March 3, 1969.

professional employees that Local 1199 was indeed the best way to represent their interests was not going to be easy.

While the ‘meeting facilities’ affair did not do much to help the organizing effort, it brought together a group of employees most committed to unionization and allowed them to articulate their message to their colleagues. In its correspondence with administration and direct appeals to the employees, the Organizing Committee grounded its message in a distinct ideological position. The organizers argued that the medical school and university as a whole had a tri-partite structure, consisting of “Faculty,” “Administration” and “Staff.” The former group was characterized as “associates,” “with whom [the employees] usually have a close working relationship” but whose efforts to improve the employees living standards are all too often “frustrated by administrative policy.” The Administration was defined as the real power holders in matters of “salary scales, pensions, health coverage, severance, sick leave, holidays, vacations and other conditions of employment.” Finally, the Staff was, according to the Organizing Committee’s leaflet, “the only group which has no voice in the decision-making process” and which it can acquire only by joining “an effective union and joining forces with other health and research personnel in 1199.”⁴³

Unlike the rhetoric used to organize non-professional employees where the issues of racial discrimination, economic exploitation and overall social marginalization were prominent, the organizing campaign among Columbia’s medical school employees articulated a vision of the semi-professional employees as a “constituent unit,” a kind of an *estate*, of the idealized “academic community,” with its corresponding rights and responsibilities. In a fine example of this corporatist rhetoric, the Organizing Committee wrote:

⁴³ P&S Organizing Committee for 1199, Robin Elliott, Interim Chairman, “Our Side of the Triangle,” open letter and meeting announcement, March 24, 1969.

Our purpose in attempting to establish a union group is to promote a more harmonious working relationship between ourselves and the other constituent elements of the University. One of the ingredients of such a relationship, we feel, is our participation in decisions which vitally affect the quality of our working lives.

At present however, charged the organizers, the Staff occupied a lowly estate, due to the Administration's abuse of its power and infringement upon the employees' legitimate rights. Reminiscent of the liberal imagery of the bourgeois revolutions, the employees demanded, both in general terms and specifically in regard to the use of university facilities, that the administration, much like the liberal State, act as an impartial and minimal 'traffic controller,' rather than an arbitrary and overbearing dispenser of privileges.⁴⁴

In broader terms, the semi-professional employees have been here re-imagined as the lower, yet legitimate part of the 'professional' estate of the modern society. In response to status anxieties, 'professional' aspirations, and 'job security' concerns, characteristic of these strata in the white-collar labor force, the organizers outlined a larger program of strengthening the position of this 'social estate' not only in a particular institution, but in the labor market at large. Indeed, in the early organizing literature, the questions of salaries and benefits were de-emphasized in favor of "enhancing skills," "upgrading and strengthening professional standards," "safeguarding job security," raising "levels and standards throughout the field" to create "continuity of salary scales, pensions and other fringe benefits" for semi-professional workers as they move across the employing institutions. As members of the 'lower professional estate,' the semi-professional employees were promised that the union would fight for their industrial interests as well, "mounting a public

⁴⁴ Kartlie to Merritt, December 2, 1968.

campaign to gain more funds for continuation and expansion of much-needed health and medical research.”⁴⁵

While the Organizing Committee’s rhetoric took pains not to alienate the semi-professional workers from their professional superiors, there were also some rather practical issues that needed to be addressed in this area. Like the voluntary hospitals, which argued that most of their operating budgets came from reimbursement by the third-parties, the medical schools insisted that most of their work was paid for by NIH grants and that it was difficult or even impossible to get them to cover salary increases. Unionization, warned the administrators, would inevitably produce lay-offs.⁴⁶

The experience of unionization at the Albert Einstein College of Medicine, where 1199 has represented the employees for a year and half, was the Organizing Committee’s strongest card both in this specific question of grants and in more general issues of employee-faculty relations. To that end, the Committee circulated a statement signed by twenty-six members of the Einstein’s faculty regarding their relationship with the union. The statement testified that the employer-employee relationships had been enhanced since Local 1199 had come to Einstein. Increased salaries and benefits, negotiated by the Union, brought the College’s pay scale close to those paid at the City’s industrial firms, enabling the School to “compete for the most talented personnel available.” The Union’s presence facilitated a better working atmosphere for the employees and a more stable relationship between staff and

⁴⁵ P&S Organizing Committee for Local 1199, “Out Side of the Triangle.”

⁴⁶ The School’s administration was aware that it was against the law to even imply to the employees that choosing the union will result in lay-offs and it communicated this message to the faculty and supervisors instead. Of course, this suggestion was out in the open and 1199 felt compelled to address it in several communications. The Organizing Committee argued that “NSF and NIH both have mechanisms for supplementing a grant to cover an across-the-board salary increase.” (“Pie in the Sky?” flier from the P&S Organizing Committee for Local 1199, undated.)

investigators. As a result, the typically high rates of turnover among the employees at medical institutions had been reduced at Einstein. The Union brought an end to the “constant struggle of the investigators to obtain raises, overtime pay, etc.,” which are now negotiated directly between employees and administration. Thus, each faculty member now “devotes his energies to the work at hand.” Finally, the Union joined with the faculty in the struggle for additional funding for the College’s teaching hospital and to expand funds for health care and medical research. The Organizing Committee has also obtained and circulated a letter of understanding between Einstein’s Director of Personnel and the Union representative regarding the ‘lay-off’ and ‘transfer’ procedures in case of retrenchment of grant funds. Einstein’s administration promised to provide the union complete information on the nature and extent of grant cut-backs and to transfer laid-off employees to other positions as soon as they became open. The Committee has also issued a comparative pay chart in order to show that the unionized employees at Einstein received considerably higher salaries.⁴⁷

In essence, the organizing strategy of the P&S Organizing Committee reflected both the ‘separatist’ strategy which underlay 1199’s new organizational structure and recognition of a different relationship of the semi-professional workers to their professional superiors and their employer institutions. The ‘third estate’-type rhetoric, articulated during the early phase of organizing drive, echoed precisely those sentiments, which the designation of the semi-professional division as the ‘Guild’ also tapped. Nevertheless, the Organizing Committee’s direct identification with Union

⁴⁷ “Statement by Faculty Members of the Albert Einstein College of Medicine Regarding Faculty-Union Relationships,” undated. “Memorandum on Retrenchment of Funds” from Mr. Joseph H. Kay, Director of Personnel, Albert Einstein College of Medicine of Yeshiva University to Mrs. Bernice Batts, Organizer 1199, September 17, 1969 with 1199 note at the top of the copy. “A Union for What?” open letter comparing medical school employees’ salaries at Columbia and Albert Einstein, undated.

1199 and even something so seemingly small as their failure to use the term ‘Guild’ or ‘technical and professional’ employees in most of their communications, may have been significant in this close contest.

The Administration’s Strategy

With almost a decade of experience, albeit from the sidelines, Columbia-Presbyterian was well prepared to conduct an anti-union campaign. When 1199 won its first victory on the Morningside campus of the University, medical school’s administration took its first steps. Certain that its higher wages, relative to other medical centers, already helped keep unionization at bay, the School threw more money at the problem. Modest salary raises were given in July of 1968 and more substantial ones were announced in December, to take effect starting January 1, 1969, when 1199 was already organizing on campus. Another wage raise was to come six months later, along with improved benefits. The raise in January was substantial, on the order of thirty percent or more. Blue Cross/Blue Shield coverage, for which employees previously had to pay, was now offered free. “Why such generosity now?” asked the 1199’s flier. “Clearly,” it answered, “the administration is afraid of the power of a union at P&S. It is afraid that, if employees get together to bargain for their rights rather than waiting to receive them at College’s whim, the wage and fringe benefits might just be more than the administration wants.”⁴⁸

In August of 1968, the School also completed a “survey of opinion by the administrative assistants,” aimed at giving the administration “a valid reading of [the employees’] present sentiments,” which Assistant Dean Damrosch discussed at his meeting with the University’s labor counsel.⁴⁹ This survey appears to have been the

⁴⁸ “Thank you, Columbia, but ...”, a flier signed “Organizing Committee of the College of Physicians and Surgeons in association with Local 1199, Drug and Hospital Union,” undated, probably December 1968.

⁴⁹ Damrosch, “Memorandum to Dean Merritt,” August 2, 1968.

very same document which, just days before the representation election, fell into possession of 1199, causing significant embarrassment to the School's administration. The document, which received growing publicity during the summer and early fall of 1969, contained 25 pages of typed reports, dated June through August, 1968, documenting a series of evaluations signed by John J. McNamara, assistant director of personnel for the University and James J. Dean, whom 1199 identified as the University's lawyer. The cover letter, signed by Thomas M. Kerrigan and dated June 27, 1968, noted that it was necessary to "organize the staff at P&S for the purpose of communicating with employees who might be called upon to vote in an election" and create "a system of key personnel in each and every department who would be the cornerstones of any organizational campaign against the union."⁵⁰

The "dossier," as 1199 christened it, contained a comprehensive list of P&S employees by department with notes pertaining to their political attitudes and views on unionization, as well as other factors, such as race and country of origin, thought to be relevant to this issue. In a report on workers in the Pediatrics department, for instance, one employees was identified as "a rabid civil rights advocate and very pro union." "Fortunately," it was noted, "her group is very small." In another evaluation, "[Miss X] reported that a girl from the Anesthesia Dept. has been talking very strongly in favor of the union. It was [Miss X's] understanding that this girl went through a marriage ceremony during the Columbia sit-in." The Ophthalmology Department, on the other hand, was described as "very loyal to the university." Apparently, there were "a number of Philipinos working in this department," and Miss X [the informant] felt

⁵⁰ Robin Elliott, Interim Chairman, P&S Organizing Committee of 1199, "Columbia is enlightened, intelligent, impartial and absolutely honest, right? ...," undated flier. "1199 Charges P&S With Stifling Union," *Columbia Spectator*, September 18, 1969; "Medical Students Sit In With the Workers," *New York Post*, September 24, 1969.

that “since many of them are waiting for citizenship papers, they might not want to get involved with any problems of the university.”⁵¹

This unfortunate stumble in the administration’s otherwise smooth campaign prompted the Dean of the College, Dr. H. Houston Merritt, to address the issue in an open letter, issued one day before the election, to dispel “all the rumors concerning this document.” First of all, Dean Merritt assured the employees that he had “never personally seen this document, nor has anyone else on the P&S Administration Staff.” He was told by the University’s attorneys that “in June 1968 one of them spoke to the Administration Assistants in order for the attorneys to gain factual information concerning the physical set-up of P&S and to ascertain department heads and supervisors in various departments.” All that this document contained, the Dean was told, are the locations of the school’s departments, names of key personnel, and, in the last column, “any comments that may have been volunteered by persons spoken to.” “At no time,” declared the Dean, “has any employee ... been threatened with this document or any action taken against any person since none of us at P&S has ever seen it.” Although clearly on the defensive, the Dean’s letter did not miss a chance to attack 1199, claiming that all evidence pointed to the fact that the document was “taken from our attorneys’ files by someone at a conference at the State Labor Relations Board.” We do not know who took it, noted the Dean, but we do know that it is being circulated by 1199.⁵²

The administration’s files suggest that confidential informants have been employed to spy on the Organizing Committee of Local 1199, as well as other activity the Medical Center found threatening. In a page-long report, received by the Dean’s Office on March 18, 1969, an unnamed informant supplied the following details of the

⁵¹ *Ibid.*

⁵² Merritt to All Supporting Staff Employees, June 26, 1969.

meeting of Executive and Issues Committees of the Organizing Committee of Local 1199.

They started to discuss the pension question. Some wanted a contributory plan whereby if an employee left after a number of years the employee could, take out what was deposited to his account. Others wanted only the employer to contribute to the pension plan. The man from Einstein said they had the former plan which in essence is a forced savings plan and they are planning to change to the latter. No final decision was made.

The next question was the meeting room. A Copy of Dr. Merritt's letter was passed around and they questioned the "interpretation" of "interfering". They want to take advantage of the next two weeks for meeting places and are planning to ask immediately for several meeting rooms such as the Faculty Room, lecture halls, etc. They think they will have about 100 people at the meeting. They plan to post notices which will contain in large letters the fact that the union won recognition to meet and to incorporate the Dean's letter in the notice.

Robin Elliott brought up the question of filing for intention to vote. Some want to delay it until the fall but the leaders seem to think they should file by April 1st. The others brought up the question of having representatives from Harlem [Hospital, P&S municipal hospital affiliate] Columbia Libraries, Computer Center and the other units which have already joined the union to Come and talk to the people here to tell them of the benefits to be derived in joining the union. Some of the employees here feel they need pointers in "educating" those other employees who do not seem to favor the union. Also they want to discuss with the Union's legal department the right interpretation of the term "interfering" in the new law.

It was the consensus that intensive floor meetings should be held immediately, and a representative on each floor is to go into each lab and talk to each person in the lab to try to get them to sign up.

Another executive meeting is being called for Friday of this week at 5:00 PM and to have a party afterwards.

The meeting broke up at 8: 00 PM.⁵³

The administration also attempted to monitor the activity of various groups agitating for change in health care services available in the Washington Heights community and the city as a whole. For instance, the Center had an informant report

⁵³ "Executive Committee meeting together with Issues Committee," one page long typed report from an unidentified informant, received by the Dean's Office on March 18, 1969.

on the “gripe and action” meeting on May 26, 1969 organized by Freedom and Peace Party aimed at airing complaints and problems with health care services offered by CPMC to local residents and its racist policies in treatment and medical school admission. An informant estimated the number of people attending (“about 100 persons”), their racial composition (“mixed, being predominantly Porto Rican and the rest both negro and white”) and the person presiding over the meeting (“one ‘Jack Mandel,’” “beatnik type, bearded, and wearing a lumberjack shirt” who was “recognized as having been on Hospital premises during the past week”). The informant reported that the main theme of the meeting concerned the Vanderbilt Clinic. “The demands are for free clinic service, with as much professional staff coverage 24 hours of the day as during the daytime hours,” “free ambulance service by the Hospital ... with admission to Presbyterian and no transfers to city institutions for all.” During the question and answer period, “one woman spoke of having to wait more than 7 hours during the night,” another “spoke of injuring her foot and when finally seen, being referred to a city hospital.” “One person defended the medical care and was booed and shouted down.”⁵⁴

The informant gave the Medical Center the heads-up on future action. “A Board composed of six members was set up by Mandel. Two were white females said to be P&S students; one white male was also said to be a P&S student. Names were not obtained, nor were the other three members known.” S/he was also able to report that a rally was called for the night of May 30, 1969, on the street in front of the building where the meeting took place, and another meeting was called for June 11th. A petition was drawn up to present to the Hospital authorities. “If this petition was not

⁵⁴ “Subject: Meeting, May 26, 1969,” one page long typed report from an unidentified informant, May 27, 1969; “Our Health is the Issue,” announcement of a meeting on May 26, 1969 organized by the Freedom and Peace Party.

successfully met, a demonstration in front of the Hospital was suggested,” reported the informant. One piece of information drew the administration’s particular attention. “Support will be asked from Local 1199,” wrote the informant, “which support was described as being so strong that any demand will be met. Also discussed was a drive to obtain the assistance of Presbyterian Hospital employees, perhaps through the Union.”⁵⁵

Having been ‘informed’ by their spy on the Organizing Committee that the leaders were likely to file for election in early April, the administration contacted the University’s lawyers to say that “this may be the proper time for the University to inform our employees of our position concerning Local 1199 and to state our views on some of the issues that the union group have raised.”⁵⁶ Over the next three months, the administration issued a number of information sheets purporting to answer the questions some employees asked about the organizing activity at the school. Invariably addressing the employees as “Our Supporting Staff,” the circulars emphasized that the employees were “not bound by union cards,” that they received three wage increases over the past 18 months, all of which were “granted without the payment of dues, without initiation fees and without a strike.” If 1199 won, warned Dean’s communications, employees would pay “\$5.50, \$6.50 or \$7.50 per month in union dues” and “[t]his also would be true of any dues charged by the SSA.” Above all, Dean told the employees, “[y]ou must vote to protect your rights” and “[w]e would like a 100% turn-out at the election poll.”⁵⁷

If the Organizing Committee for 1199 articulated a corporatist vision of the employees’ rights within the academic-professional community, the Administration

⁵⁵ *Ibid.*

⁵⁶ Merritt to Joseph P. Nye, Business Manager, 313 Low Memorial Library, Columbia University, March 21, 1969.

⁵⁷ Merritt to All Members of the Supporting Staff, June 24, 1969.

sought to encourage individualism among their employees, an attitude opposed to collectivism and bureaucratic leveling. In one of the ‘Question and Answer’ circulars distributed close to the election, the Administration warned the employees that, should a union win, all employees would be compelled to join the union, whether they want to or not, or else they will be discharged. Such coercion, implied the Administration’s message, is utterly intolerable and grossly violates individual freedoms.

As a matter of principle, the Medical School believes that each of its employees should be free to decide for himself or herself where he or she wished to belong to a Union and that the Medical School itself should be free to hire employees ... regardless of their Union affiliations. Unfortunately, if the union wins the election, neither the Medical School nor the employees may have any choice concerning the question of compulsive unionism. The only way an employee can be certain that he won’t be compelled to join a union as a condition of employment is for him and his fellow employees to vote “No” on election day.

If compulsory unionism was not scary enough, the Administration’s circular warned the employees that, on top of hefty union dues, union members will also be subject to the imposition of special assessments to meet any special needs. “These special assessments,” it was explained, “are often for political purposes, that is, for contributions to campaign funds of a particular political party.” As a result, “union members are sometimes required to make contributions to political parties which they oppose.”⁵⁸

Administration’s ‘information’ sheet took pains to depict the union as a rigid, leveling organization. Once a union is established, warned the administration, it is impossible to remove it, since “the New York State Labor Relations Board has no procedure for getting rid of [the unions], not even if an overwhelming majority of the employees want them out.” The union will eliminate “merit [salary] increases as a

⁵⁸ “Memorandum” in the question and answer form regarding unionization, unsigned, undated.

practical matter, if not by the express terms of the contract.” In short, “the Medical School would take on several of the undesirable aspects of the Civil Service System.” Finally, the union may negatively effect the working atmosphere at the medical school. The “union shop stewards in each department would cause as much disturbance as motivated by their own personalities. In some departments there will probably be no difficulty. In other departments constant strife.”⁵⁹

Remarkably, a series of similar communications – in the form of memoranda or even the familiar question and answer sheets – were sent to the Chairmen of Departments and other members of the professional staff. “May we give you some additional information concerning the election on Friday, June 27th,” began one of these letters. Only two days remaining before the election, the Dean pronounced three points, which he apparently deemed necessary for the chairmen to know. The first concerned the union shop provision, which the Dean wrote existed in “each contract Local 1199 has with the University on campus and at Harlem Hospital,” as well as at Einstein and other institutions under contract with the Union. After explaining that the union shop provides that existing and new employees must join the union or be discharged, the Dean raised the more important point about this provision.

This provision becomes most important for Local 1199 at P&S since it would guarantee them approximately \$100,000 per year in dues and initiation fees. The arithmetic is easy - there are approximately 1,230 employees eligible to vote in the three units; Local 1199's dues structure is \$5.50, \$6.50 or \$7.50 per month depending on an employee's salary. By multiplying 1,230 x \$6.50 we arrive at \$7,995 per month in dues, or nearly \$96,000 per year. If we hire only 175 employees during the year this would bring the union another \$25 per person in initiation fees or over \$4,000 per year, for a grand total of \$100,000. Do you think the union would permit us to have a contract without a union shop?

⁵⁹ *Ibid.*

This must have been calculated to arouse the chairmen's outrage at the over-paid unionists.⁶⁰

Dean's next point was research projects. "Most of our research," stated the Dean, "is paid by NIH" and, "[a]s you all know, it is difficult if not impossible to get any of these grants increased to cover any increase in salaries or fringe benefits." In the event that one of the unions wins the election and demands salary and fringe benefit increases, "most grants will not have sufficient monies available to cover the added cost." The only solution would be for the University to absorb the added costs or to layoff employees. "It can be stated emphatically," wrote the Dean, "that the University is not financially able to pick up any such cost." But the most disturbing message was that the administration had "heard" that at Einstein, where such demands have been already made, "Local 1199 has threatened to strike if Einstein fails to layoff *faculty members* at the same time they layoff technical employees."⁶¹

The final point of the letter was a "100% turnout." "It is our goal," wrote the Dean, "that every eligible employee have an opportunity to cast his ballot in SECRET on Friday, June 27, 1969." In case the senior faculty missed the point of this directive, the Dean stressed that it was "incumbent on each department head or supervisor to see to it that each eligible employee is given sufficient time off to go down to vote."⁶² These and other communications were obviously directed toward diminishing the extent of sympathy or, at least, non-interference which professional staff might have granted their semi-professional colleagues in the throws of unionization struggle. The strategy was to arouse fear for the future of the professionals' own careers, closely bound, as was implied, with the fortunes of the institution in which they worked.

⁶⁰ H. Houston Merritt, M.D., Dean, College of Physicians & Surgeons of Columbia University, "Memorandum to Chairmen of Departments," June 25, 1969.

⁶¹ *Ibid.*, my italics.

⁶² *Ibid.*

The crux of the Administration's strategy was to individualize their employees and to reach each one in the most effective way. Whether or not the kind of information gathered in the infamous personnel dossier was actionable under the watchful eye of the union is rather unclear but it is obvious that the administration did try its best to exploit every difference it could. Whether it was pending immigration cases of Philippine employees or the peculiar subordination of the female secretarial corps to the personal authority of their bosses, administration strove to know and to use particular and individual vulnerabilities. As an institution, P&S had come a long way from the days when the top administrators would never bother communicating directly to their lower-level employees and when all matters pertaining to them were left in the hands of their immediate bosses. Now, communication was frequent and, sometimes, even personal. Many communications were in Spanish as well.

In its anti-union strategy, the medical school was not merely trying to discover particular differences among its employees that it could use to its advantage. To a large extent, the organization had created and fostered those differences as well. Medical school's highly fragmented structure, in which the employees were scattered among multiple physical locations, hospitals, and departments, was an invaluable asset in the administration's fight. Independent department operations and fragmented funding structure also helped the administration make the case against joining the larger union. Finally, the medical school's professional and educational work daily symbolized a larger vision of individual achievement projected throughout the entire cultural space. Individualist worldview, opposed to all collectivism, was something that the administration was happy to cultivate in the minds of their employees.

The Employee Association's Strategy

Whether or not the school's administration had a hand in launching the SSA itself is unclear but some facts certainly point to that conclusion. First, of course, was

the urging of the University's lawyers that the School should choose 'the lesser evil,' rather than resisting unionization outright which might only increase 1199's appeal. Events at Einstein also suggested that medical school employees might be interested in establishing their own, rather than an outside, employee organization. Second, the Supporting Staff Association was apparently retaining a lawyer, an unusual fact for a fledgling employee organization which was yet to collect any membership fees, and its earliest communications featured highly precise and legalistic language.⁶³ The flier inviting employees to an 'interest' meeting, for example, consisted of two paragraphs headed "Purpose" and "Prospectus," and included such precisely worded clauses as "when our organization is accepted by the employees with a majority vote" or "the present proposed structure is to obtain two (2) representatives from each department."⁶⁴

Last but not least, the SSA's early appeals defined the organization in distinctly co-operative and amicable terms. "Many of us," read the prospectus, "who have been employed by Columbia University for a number of years, have had a good relations with the Management and Supervisors and wish to continue this relationship; however, we of the Supporting Staff desire to have the potential to shape our future on a fair basis to us and the Management." The Association's accommodating posture was apparently reciprocated by the administration. Unlike the Organizing Committee for 1199 whose requests to use University meeting facilities had been repeatedly denied, all of the SSA meetings took place in the School's buildings. During the months leading to the union elections, the School's administration had also adopted

⁶³ "To All Workers at P.& S," open letter from the medical school students starting signed "Ad Hoc Medical School Committee," undated.

⁶⁴ Open letter signed "Supporting Staff Association of the College of Physicians and Surgeons of Columbia University" announcing the organization's purpose, prospectus and meeting on February 24, 1969, undated.

the phrase “Supporting Staff” as a standard address in all official communications with its employees.⁶⁵

First gently and then more aggressively, the SSA’s communications suggested that it was a genuine, home-grown organization established by and for the P&S employees, whereas Local 1199 was an impersonal, distant organization interested exclusively in extracting the school’s employees union dues and inclined to employ any methods to achieve their goals. After the administration’s personnel dossier has been uncovered by 1199, the SSA issued a statement confirming that the Association “has seen the personnel dossier on P&S employees as reported by 1199.” While emphatically denouncing the administration’s “spy action,” the SSA also condemned “the action of 1199 in acquiring such information by whatever devious method.” The Association, said the statement, “has never and will never engage or endorse such scurrilous tactics” proceeding, in the remainder of the document, to attack 1199 as a distant, unresponsive extractor of union dues.⁶⁶

⁶⁵ *Ibid.* That the administration was involved in establishing the SSA is also suggested by the official call from two members of the Columbia’s University Senate for volunteers to develop an independent organization for administrative staff, issued on March 31, 1971. This appeared just over a month after the University’s Business Officer, Bernis D. Moss, Jr. learnt that Local 153, Office and Professional Employees International Union, which represented supervisory employees at Albert Einstein School of Medicine, planned to “open a store-front office at 165th Streer and to organize the supervisors at P&S.” (Moss to Messrs. Merritt, Damrosch, Adams, Nye and Paranda, February 24, 1970.) Of course, it is possible that the school’s administration did *not* have any involvement in establishing the SSA. It appears that during this time both union organization and union busting in New York City became a lucrative business attracting entrepreneurial lawyers. As the open letter from medical students suggested (“To All Workers at P.&S.”), the SSA’s lawyer [likely Peter Curley, the name which come up in later documents] also “[worked] for several other unaffiliated groups.” Interestingly, the letter from the students warned workers that some of these unaffiliated unions, represented by the same lawyer, “have used reprehensible tactics in organizing or representing the workers.” One union was cited by the New York State Labor Relations Board to “‘have acted in blatant disregard of the workers’ statutory and constitutional right to representatives of their own choosing.’ (In Charles Eagle Holdings, Inc., 26 SLRB 307, 309” Thus, it is not inconceivable that the lawyer approached either the employee(s) or the administration of P&S with a proposal to offer his services to help organize an unaffiliated in-company union.

⁶⁶ Open letter from Supporting Staff Association of the College of Physicians and Surgeons of Columbia University, June 25, 1969.

As election time neared, SSA stepped up its efforts to distinguish itself from its rival. “You will be asked,” read one pre-election letter, “to decide whether you wish to be represented by an organization founded and managed by you co-workers, whom you know, or whether you wish absentee representation supplied by a group of strangers.”

The leadership of the SSA knows your problems better than any stranger ever will. ... Every time a problem arises it will require a call to an office in downtown New York where it will be processed in an impersonal way. You might inquire of your friends at other hospitals about the kind of brush-off they have received from that office. Don’t be misled by the fact that the other union has an organizing committee composed of P&S employees. The chairman of that committee is leaving P&S on June 30. You may be certain that after the election this committee won’t mean a thing and that full control will pass into the hands of the union professionals if they should win. ... We know that Local 1199 plans to suppress you with enormous dues. ... We assure you that you will get more effective representation by the SSA for far less financial endorsement.”⁶⁷

All in all, this was a message, with which the School’s administration would have hardly disagreed.

The First Union Election at P&S

The New York State Labor Relations Board determined that a little over 1200 employees of the College of Physicians and Surgeons were eligible to vote in a representation election. The employees were divided into three voting units: technical workers, with 603 employees; clerical workers, with 437 employees, and service workers, with 170 employees.⁶⁸ Table 6.1 summarizes the election results in the three units.⁶⁹ The differences among the units were quite telling. Both in its leadership and

⁶⁷ *Ibid.*

⁶⁸ Numbers derived from “Election Results,” the memorandum from Dean Merritt to all Supporting Staff Employees, July 2, 1969.

⁶⁹ The challenged ballots in the clerical unit could have affected the result of the election but the result stood on review by Labor Relations Board. (Merritt to All Supporting Staff Employees, August 22, 1969.)

Table 6.1. *Results of the First Union Elections at Columbia University's College of Physicians and Surgeons, June 27, 1969*

Voting Unit	Total Votes Cast in Each Unit		Voting for 1199		Voting for SSA		Voting for No Union	
	#	%	#	%	#	%	#	%
Technical	497	100%	204	41%	173	35%	120	24%
Clerical	375	100%	120	32%	70	19%	185	49%
Service	142	100%	57	40%	45	32%	40	28%

Source: Calculated from C.D. Auty, Assistant Vice President for Personnel, Presbyterian Hospital, to Dean Merritt and the Administration, "Record Memorandum," July 3, 1969.

message, the 1199 organizing drive at P&S had focused on semi-professional and, especially, technical, workers. The message of professionalism, workplace democracy, idealized academic community and entitlement to decent wages and benefits were obviously most appealing to this group of workers. The clerical unit, which turned out to be most convinced by the administration's message, reflected both its gender composition and its distinctive relationship to administrative hierarchy and function. Since, none of the three election choices presented at the representation election received the majority of votes required to win and the Labor Relations Board ordered run-off elections between 1199 and the SSA in all three units. Due to summer vacations, the University requested that the run-off elections be postponed until the fall and the date was set for October 3, 1969.

Although not an outright rejection of unionism, the results of the June election must have been reassuring to the officials at the medical school and the university. They still had a clear chance to carry through their Plan B, any union but 1199. "[A]m I correct in thinking that we should now make every effort to get those who voted for No Union to vote for the S.S.A ... ?" read a hasty note from the Chairman of the Department of Urology to Dean Merritt. "No answer to this is needed," he added,

“unless I am wrong.”⁷⁰ Indeed, no response seems to have been sent, although at the end of September, in one of its by now quite regular communications administration assured employees that “[t]he University’s position in this election is one of neutrality” and that it “will negotiate in good faith with the winner.”⁷¹

The results of the run-off representation elections between Local 1199 and the SSA were as shown in Table 6.2. Run-off vote results were very close in Technical and Service units and the University and the two unions were allowed to file briefs with the Labor Relations Board. The preliminary results of the election stood and SSA was certified as a collective bargaining agent for all three units.⁷²

Table 6.2. *Results of the Run-Off Union Elections at Columbia University’s College of Physicians and Surgeons, September 3, 1969*

Voting Unit	Total Votes Cast		For SSA		For 1199	
	#	%	#	%	#	%
Technical	451	100%	233	52%	218	48%
Clerical	373	100%	240	64%	133	36%
Service	130	100%	66	51%	64	49%

Source: Calculated from Dean Merritt to All Supporting Staff Employees, memorandum on October 3, 1969 election results, dated October 6, 1969.

The First Union Election at Presbyterian

Nominally, the first ever union election at the Medical Center spelled a limited victory of the administration, insofar as the Union Local 1199 was defeated by what may well have been a ‘company union.’ A host of unsettling questions regarding the SSA’s constitution and legitimacy arose immediately after the election and indicated

⁷⁰ John K. Latimer, M.D., Chairman, Department of Urology to Dean Merritt, July 7, 1969.

⁷¹ Dean Merritt to All Supporting Staff Employees, September 24, 1969.

⁷² Merritt to All Supporting Staff Employees, October 31, 1969 and February 10, 1970.

that the battle was not yet over. This probing was a work of a small but active core of the school's employees who were determined to continue working for more aggressive, independent union representation. Another confirmation that 1199 was not to be written off at the Medical Center came early in 1970, when the first ever group of Presbyterian employees voted to join the Local and petitioned the NYS Labor Board for a representation election. The group in question was one of the smallest units of the Hospital, the Department of Social Work, with a 24-person, all female professional staff. The Department's slight size, however, did not indicate that the university would not aggressively fight the proposal.

Upon learning of the social workers' intention to organize, Presbyterian's administration immediately launched a legal campaign to thwart their effort. A series of objections filed by the Hospital succeeded in considerably delaying the election, although not in preventing it altogether. Five months after the filing, the Labor Relations Board had finally reviewed the Hospital's objections and ordered the election to be held. Predictably, the administration tried to persuade the social workers to vote against the union. Their attempt failed, however, and on June 3, 1970 the social workers voted 18 to 6 to be represented by Local 1199.⁷³

Despite the results of the election, the Hospital refused to negotiate a union contract with the social workers. Instead, it again proceeded to file a number of objections to the election with the New York State Labor Relations Board. On February 9, 1971, or nearly eight months after the social workers voted for the union, the Labor Relations Board finally managed to go through the barrage of motions filed

⁷³ "Presbyterian Hospital Violates the Law," Flier in English and Spanish, undated, filed June 20, 1970.

by the Hospital and strongly dismissing them as “frivolous” and stating that “the hospital had tried to ‘make a merry-go-round of our election procedures.’”⁷⁴

After the Board reaffirmed its certification of Local 1199 as a collective bargaining agent of the social workers, both the employees and the union officials repeatedly tried to contact the hospital administration to begin collective bargaining, as directed by the court decision. These efforts were met by a concerted refusal of the administration to meet or negotiate with their social workers. As the social workers recounted in their letter to the Chairman of the Hospital’s Board of Trustees, “Presbyterian has chosen not only to flaunt the courts and the law by refusing to talk with its Social Workers, but has also filed new objections to the elections.”⁷⁵

After more than a year of futile attempts to get the Hospital to recognize the union, the social workers sought to publicize their case to a wider audience and help put pressure on Presbyterian’s administration. A copy of their appeal to the Hospital’s Board of Trustees to amicably resolve the situation was sent to the Association of New York Schools of Social Work, National Association of Social Workers, New York City and New York State Commissioners of Social Services, Community Council of Greater New York, and the United Fund. Apparently immune to threats of “public embarrassment,” the Presbyterian continued a legal strategy of delay and evasion.

During more than two years of legal battle, the State Labor Relations Board had consistently ruled in favor of the Social Workers and the Union, the arbitration hearings resulted in support of the Union, and the State Supreme Court also upheld the decision of the State Labor Relations Board. Despite consistent findings in favor of

⁷⁴ Letter from Social Work Chapter, Presbyterian Hospital, Local 1199 to Mr. Augustus C. Long, Chairman of the Board, Presbyterian Hospital, March 15, 1971. Copies sent to Members of the Board, NY Schools of Social Work, NASW, NYC Commissioner of Social Services, Community Council of Greater New York, United Fund, NYS Commissioner of Social Services.

⁷⁵ *Ibid.*

the social workers' right to union representation, Presbyterian refused to accept these decisions, appealing them where possible and initiating new legal processes to justify its continuing disregard of the courts' injunctions to recognize and negotiate with the union. In May of 1972, for instance, the Medical Center administration requested that the Appellate Court delay hearings on the Union's petition, noting that the Medical Center has asked that Court to rule first on its own petition which involved questions about which Social Workers were eligible to vote for a bargaining unit and what is to be considered a Social Work Unit in the Medical Center, providing yet another fine example of the Hospital's hairsplitting legal tactics.⁷⁶

Stonewalled by the Hospital's refusal to recognize their rights, the social workers turned to their professional organization. On June 28, 1972, the workers filed a complaint with the New York City Chapter of the National Association of Social Workers (NASW), alleging violation of personnel standards by the Presbyterian Hospital. and asking for a special inquiry into the case. Accepting the case, NASW appointed a committee to conduct an inquiry. At a hearing, held on October 17, 1972, where a representative of the Hospital was present, along with the Hospital's lawyer as a witness, the Special Inquiry Committee determined that the Hospital indeed "failed to acknowledge and comply with the bargaining rights of its Social Workers," the rights which had been clearly defined in a policy statement on labor-management relations in social work issued by the NASW. The Committee concluded that the Hospital was guilty of repeated disregard for the decisions of the courts and that its own personnel policies in regard to the social workers were grossly deficient. In particular, the Committee established that "while the Medical Center has a set of

⁷⁶ "Report of a Special Inquiry Committee on a Complaint of Alleged Violation of Personnel Standards in Social Work," Board of Directors, New York City Chapter, National Association of Social Workers, November 15, 1972.

personnel practices, published in an Employees Handbook, only at the hiring point are Social Workers informed of the conditions of their employment.” Social workers did not have access to the Handbook which, in any case, “ does not include all of the personnel practices which apply to them,” as the Medical Center representative admitted at the hearing. Although the social workers had drawn up a set of personnel practices and submitted them to the Director of the Social Service Department, 18 months later “there [still] has been no response to the document nor any indication that the Social Workers could participate in any process which would deal with changes or additions to the Medical Center personnel practice.” The Committee concluded that, at Columbia-Presbyterian Medical Center, “the basic responsibility which the Social Workers have in labor-management relations, namely to participate in the formulation of personnel policies and procedures which affect them on the job, is being denied them.”⁷⁷

The NASW Committee recommended that the Medical Center administration “recognize the rights of the Social Workers to select their own bargaining unit (union). This principle, they emphasized, as enunciated by the National Association of Social Workers, “operates for the Social Work Profession throughout the United States and applies to health and welfare agencies, publicly and privately supported, and of all sizes and organizational structures.” The Committee also enjoined the administration to work together with representatives of the social workers “to review and revise, as necessary, the personnel practices, of the Medical Center and to make the copies of such personnel practices be easily available to all of the Social Workers.” In doing so, the Committee urged that “the National Association of Social Workers’ Personnel

⁷⁷ *Ibid.*

Standards, which defines the rights, responsibilities and commitments of Professional Social Workers, be utilized as a guide.”⁷⁸

As might have been expected, the recommendations of the NASW, the largest professional organizational of the social workers were ignored. Almost eight months after their inquiry, the Association used its final and ultimate weapon, issuing a statement in which it urged

that members of NASW refuse offers of employment in the Hospital; that graduate schools of social work not use the Hospital as a field placement for their students; that related professional organizations and governmental and private funding and accrediting agencies review their relationship with the Presbyterian Hospital in the light of this institution’s persistent efforts to deprive its employees of a commonly accepted right of all workers in our society – the right to organize in a union of their own choice and to bargain collectively with their employer on matters of working conditions, personnel practices and salaries.⁷⁹

Internal Opposition to the SSA

While the struggle of the twenty-four social workers against the Presbyterian Hospital unfolded in the courts, the 1199 supporters at P&S continued their struggle, albeit now from the inside of SSA. Soon after the certification of the SSA as an exclusive collective bargaining agent for P&S employees, an internal opposition group formed the Committee on Election Procedures (originally the SSA Subcommittee on Elections). Frustrated by the secrecy surrounding the SSA governance, constitution, and negotiations with the administration, the Committee secured a court order served on Otto Gonzalez to show cause why he should represent the SSA and to enjoin him and the Executive Committee from any further collective bargaining negotiations on

⁷⁸ *Ibid.*

⁷⁹ Dr. Louis Levitt, President, NYC Chapter, National Association of Social Workers, to William McGill, President, Columbia University, July 12, 1973.

behalf of the SSA.⁸⁰ The order forced Mr. Gonzalez to submit the SSA Constitution. Previously, Mr. Gonzalez had failed to file it with the Labor Department (a violation of the law) and refused to make the constitution available to those SSA members which demanded to see it. Although the court ordered Mr. Gonzalez to make the Constitution public, the self-appointed President of the SSA refused to print, leading the Committee on Election Procedures to print it at their own cost and to issue an open letter to all P&S employees describing this document as grossly undemocratic. Quoting from several articles, the opposition group revealed that the SSA Constitution reserved most powers – including amendments to Constitution – to the Executive Board. It further stipulated that the first election to the Board would not be conducted until March 1972 and that only those who have been members of SSA prior to September 1969, i.e. before the final run-off elections, would be eligible for office. In effect, no decisions would be ratified by the vote of the SSA membership.⁸¹

The Committee on Election Procedures wrote that it was clear why Mr. Gonzalez had repeatedly refused to provide the text of the Association's Constitution. It was "a totally undemocratic and authoritarian document" that "leaves each of us, whether a member of the S.S.A. or not, at the mercy and absolute control of a self-perpetuating Executive Board." The Committee called on the P&S employees to fight for a democratic union.

By conducting secret negotiation and disregarding the mandate of the 400 workers at the Dec. 17 meeting, Mr. Gonzalez and the Executive Board of the S.S.A. have show their lack of respect for the employees and their fear of employee participation. When the leadership of a union disregards the

⁸⁰ Angela Harras and Jennifer Brandisi, for the SSA Subcommittee on Elections, to the Trustees of Columbia University and the Administrators of the College of Physicians and Surgeons, undated. B.D. Moss, Jr., Business Officer, to Messrs. Merritt, Damrosch, Adams, Nye and Paranda, January 15, 1970; "Dear Fellow Employee, Re: S.S.A. Constitution," Committee on Election Procedures, undated.

⁸¹ "Dear Fellow Employee, Re: S.S.A. Constitution," an open letter from the Committee on Election Procedures, undated.

interests and ideas of those it represents and seeks to protect and perpetuate its own leadership position with an undemocratic constitution, it is therefore incapable of negotiating a contract which will solve our problems or satisfy our needs.

The opposition Committee declared itself open to participation by any employee and urged P&S workers to join them “in the creation of the widest, most unified base of struggle to win from the Columbia Administration the best possible wages, job conditions and job security.”⁸²

The opposition to the SSA leadership proved tenacious and the Committee on Election Procedures came to function as an alternative union structure with its own newsletter, coordinating location, floor representatives, and subcommittees on issues ranging from health care to contract negotiations. The opposition criticized the terms of the contract which the SSA leadership managed to negotiate in secret, demanded disclosure of the President’s salary and budget, and called for a vote to adjust an exorbitant fee “23,500 for 470 hours” presented to the SSA by its lawyer, Peter Curley. Making little head-way in changing the undemocratic structure of the SSA, the Committee called on the employees to stop paying dues to the SSA dues and to deposit them instead into a special checking account until such time as the SSA leadership conceded demands for democratic governance of the Association.⁸³ Unable to eliminate the internal opposition, the SSA leadership attempted to take charge of the open meetings of the opposition’s committees and steer its activity onto a narrower

⁸² *Ibid.*

⁸³ Open letters from the Committee on Election Procedures to “Dear Fellow Employees,” June 11, 1970 and June 17, 1970 and to Dean Merritt, June 16, 1970. The Committee’s other initiatives are documented in “File Memo” from Moss regarding the meeting between the SSA Health Committee, July 19, 1970 and the SSA Health Committee to Paul A. Marks, Vice President in Charge of Medical Affairs, September 2, 1970.

path. As its newsletter said, the Committee on Election Procedures was working to broaden the SSA members' benefits "[i]n spite of the Executive."⁸⁴

The opposition had to fight the battle on two fronts: one against the SSA leadership and the other against the school's and Columbia's administration which was only too happy to assist the SSA in fighting what they both understood to be a 1199 inspired faction. The administration issued appeals to employees to pay the dues and to ratify the collective bargaining agreement negotiated by the SSA. It also allegedly asked administrative assistants to speak to employees and urge them to refrain from answering the protest calls of the internal opposition group. The Committee on Election Procedures protested what it saw as illegal interference of the employer into the internal affairs of the employees' organization.⁸⁵

Notably, just as before the election, some of the work of Local 1199's supporters at P&S was actually benefiting the SSA. It is doubtful, for instance, if the SSA could have convinced P&S to unionize on its own. On the contrary, its very emergence which, unlike at Einstein did not precede entry of 1199, seemed parasitic on the Union's effort. In a struggle which opened a dangerous lacuna between the administration and 1199, the SSA had the advantage of offering a comfortable middle ground. After the victory of the SSA, the 1199's supporters had little choice but to move their struggle inside, that is, from within the organizational framework of their rival. For reasons other than the 'union shop' rule, the loyal opposition approach was probably the best post-defeat strategy for 1199's supporters, since the majority of their fellow workers had indeed voted for the SSA. If the 1199 faction, however, succeeded in making the SSA a better, more democratic organization, as they declared, or if they

⁸⁴ "The Voice of P&S Employees," Newsletter of the Committee on Election Procedures, September 3, 1970.

⁸⁵ Merritt to All Supporting Staff Employees, March 18, 1970 and June 15, 70. Committee on Election Procedures to Dean Merritt, June 16, 1970.

won some benefits the SSA leadership did not bother to fight for, they were giving their fellow employees the advantages of a stronger, more aggressive union without the need to actually affiliate with one. Whether their strategy would eventually produce a broad desire for a different kind of union was uncertain at this point.

In the spring of 1972, however, 1199 and its supporters at P&S decided to try their luck once more and filed for a representation election.⁸⁶ In preparation for the vote, the administration did its best to convince the employees to either vote for ‘neither union’ or for the SSA. Open letters in both English and Spanish were issued, promising continuation of salary and benefit increases with or without the union and warning that choosing 1199 would result in higher union dues and likely loss of income during an impending city-wide strike.⁸⁷ In a not-so-subtle manner, the administration wrote to the faculty members to explain that the National Labor Relations Board, under whose jurisdiction the coming union election would be conducted, in the case of a run-off election, the national board stipulates “a run-off between the 2 highest vote getters while the State Board has the run-off election between two unions.”⁸⁸ Out of 956 valid ballots cast on May 24, 1972, 464 were for SSA, 421 for 1199 and 71 for neither union. The run-off between SSA and 1199 again ended in close victory of the SSA, 465 to 435.⁸⁹

⁸⁶ Ivan C. McLeod, Regional Director, National Labor Relations Board, to Columbia University for Physicians and Surgeons (sic), April 4, 1972. Frederick B. Putney, Assistant Vice President in Charge of Medical Affairs, Columbia University, to All Columbia University Personnel, April 7, 1972 and April 24, 1972.

⁸⁷ Putney to Columbia University Supporting Staff Personnel, May 17, 1972, open letter in English and Spanish.

⁸⁸ Putney to Members of the Faculty, May 3, 1972. The implication here was that, if the results of the upcoming election were similar to the initial ones in 1969, run-off elections is clerical unit, for instance, would be between “No Union” and “1199,” which might create a chance to be rid of the union contract for the clerical workers altogether.

⁸⁹ Putney to All Supporting Staff Employees, June 14, 1972. C.D. Auty to Supervisors with elections results certified by the National Labor Relations Board, June 23, 1972.

Although preserving the status quo, the election results showed some changes. If in the original run-off contest between the SSA and 1199, the former won by 8 percentage points, a year and a half later, the margin of victory was less than 3.5 percent. More importantly, if a whopping 34 percent of all P&S employees voted for “neither union” in June of 1969, now only seven percent made this choice. Clearly, the presence of the employee’s organization dispelled many myths and fears about its adverse effects, propounded by the administration in the months before the first election, and even as flawed a union as the SSA was felt to be better than no representation at all.

In spite of this defeat, support for 1199 among P&S employees persisted. Following the experience of unionization at Albert Einstein College of Medicine, 1199 supporters began to campaign for affiliation, rather than another election. Although the move succeeded in mustering a 3 to 1 membership vote to hold a referendum on affiliation, the effort failed due to what seems like an intentional procedural mismanagement of the referendum by the SSA leadership.⁹⁰

Breakthrough Election at Presbyterian

An appeal to the social work profession, undertaken by the beleaguered social workers in 1973 with the goal to shame Presbyterian into recognition of their collective bargaining rights, would most likely have been futile if a new factor had not entered into the equation. In 1973 Local 1199 finally committed all its resources to organizing the Hospital’s non-professional workers. A few months previously, the Union had been contacted by a rank-and-file group at Presbyterian, who called

⁹⁰ Otto Gonzalez, President, SSA to All SSA Members, June 6, 1973; SSA Executive Board Members to SSA Membership, June 27, 1973; Gonzalez to All Supporting Staff Members, “Results of the Primary Election Held on July 18, 19, 1973,” July 26, 1973; Neal T. Dorman, Lowenthal, Freedman, Landau, Fischer & Todres, P.C., to Gonzalez, August 30, 1973 and September 5, 1973; SSA Members for Affiliation to Gonzalez, September 11, 1973; “SSA Presidential Report #1,” September 1973.

themselves Sisters and Brothers United and had tried without success to gain union recognition for over a year. Believing that the time was finally right, Elliott Godoff assigned Eddie Kay, the Union's vice president and director for the Queens-Long Island organizing team, to lead the day-to-day organizing drive. At the start of this effort, Kay concluded that the union had gotten nowhere at Columbia-Presbyterian because it had "tried to change the boss instead of organizing the workers first," Kay created a rank-and-file organizing committee that quickly grew to include 150 workers. Previous organizers, he felt, had been "too defensive," too accepting of the hospital's definition of itself as "impregnable. They thought they were hot shit and they could do no wrong. . . . And we always approached them from that angle." One of the first indications that 1199's drive was succeeding was a massive demonstration in November 1972. Workers crowded into the hallway outside the office of the hospital's personnel director and demanded an early certification election.⁹¹

Presbyterian's administration countered 1199's efforts with a campaign that appealed to the workers' economic self-interest. One of the Hospital's first moves in the months before the election was to announce an increase in wages which were already comparable to 1199 standards. This gesture was followed by communications stressing that Presbyterian's workers were already better off than those represented by 1199 in other hospitals. "Do you want less insurance coverage?" asked one of the Hospital's pre-election fliers showing that employees under 1199 contract at other hospitals received less coverage than workers at Presbyterian had without the union. Another flier invited the workers to "compare [their] present rate of pay with the pay of union members in hospital organized by 1199," citing average pay rates that placed

⁹¹ This discussion adopted from Fink, *Upheaval*, p. 166.

Presbyterian above the Union and reminding employees that “at Presbyterian Hospital [they] are scheduled for a salary increase every six (6) months.”⁹²

In another kind of economic appeal, administration’s Q & A Bulletin No. 1 printed answers to the following question allegedly “asked by our people ... about the Union election.”

Q. Why does the union want me to sign a card?

A. For the same reason that they tried to get the Hospital to recognize them as your exclusive representative without an election – so they can get into Presbyterian Hospital and require dues payments of \$90 per year from each of 1,500 employees for a total of \$135,000 plus fines, fees and assessments.⁹³

Still, as one rank-and-file leader observed, “not once did the hospital ever respond to our organizing efforts by trying to meet the workers’ biggest beef – the lack of respect for people as human beings. All they could think of to do was to try to pay workers off with money, or use fear and phony buddy-buddy stuff.”⁹⁴

Pre-election consultations between the Hospital, the Union, and the State Labor Relations Board resulted in designation of two voting units, one comprising a little over one hundred workers in the maintenance and engineering department and another consisting of fifteen hundred service workers. In the first unit, employees decided against 1199 representation in a 3 to 2 vote. Among the service workers, however, 1199 won by an impressive margin of 878 to 507 votes.⁹⁵ The results were consistent with 1199 experience elsewhere. Engineering and maintenance departments generally had better paid positions and fewer minority and women workers. Their response to 1199’s militant, minority-rights inflected campaigns was

⁹² C.D. Auty, “Comparison of Life Insurance Coverage,” January 4, 1973, and “Comparison of Weekly Rates of Pay,” January 2, 1973.

⁹³ C.D. Auty, “Q & A Bulletin No. 1,” January 3, 1973.

⁹⁴ Quoted in Fink, *Upheaval*, p. 166.

⁹⁵ C.D. Auty to All Employees, Re: Union Elections, March 2, 1973.

mixed. Presbyterian's service departments, on the other hand, had much higher proportions of both minorities and women and were more receptive to 1199's dual union rights and civil rights message. Nevertheless, in a large voting unit, many factors were bound to work against agreement and unity and an employer as strong and determined as Presbyterian Hospital was sure to exploit them. Apparently, however, 1199's message of empowering the workers to deal with their employers from a position of collective strength resonated strongly even among the better paid service workers.

Soon after 1199's tremendous victory among the Hospital's non-professional workers came the final resolution of the social workers' three-year long struggle. In October of 1973, the social workers finally won a union contract from the Hospital, which included a salary raise with back pay to 1971, effective grievance procedures, and improvements in working conditions. The story of their struggle was instructive. Over a period of three and half years the Hospital chose to spend over \$100,000 in legal fees, as well as countless hours of labor by their administrators and employees to prevent thirty or so social workers from obtaining and exercising collective bargaining rights.⁹⁶ In the end, it was neither the courts, nor the professional association, nor public embarrassment that forced the Hospital to accede to the social workers' demands but the overwhelming victory of their fellow non-professional workers. Clearly, Presbyterian fought so hard because it was sure that the recognition of the social workers' right to be represented by Local 1199 would open the door for this most feared union to organize the rest of the Hospital's workers. But the fact that it was twenty-four women in a semi-professional field highly dependent on institutional employment who defied both their mammoth employer and the 'professionalism' of

⁹⁶ "Open Letter from Presbyterian social workers to our co-workers who are voting December 12th," undated.

their work, seems relevant as well. All these considerations and the length to which the Hospital's leadership went to deny the union rights of thirty female social workers, should have served as an important omen to both women and men at the bottom of the professional middle-class in regard to their social status and their relationship to the non-professional working class.

With the stunning victory among the non-professional workers, 1199 was finally poised for success among other employee groups at Presbyterian and P&S. In the fall of 1974, the Technical and Professional Organizing Committee secured sufficient support to petition the Labor Relations Board for elections and on December 12 the technical workers unit voted 257 to 75 for 1199 representation. Around the same time, the Office and Clerical Employees Organizing Committee was formed and set to work. Its election was set for March 4, 1975.⁹⁷

Path-breaking vote of the Hospital's service workers seemed to have finally shattered the atmosphere of fear among Presbyterian's staff. Organizing Committees for other employee groups included large numbers of people from the outset and employees in as yet unorganized units gave free and open endorsements to the Union and unionism. A large and diverse group of Organizing Committee members was portrayed on the cover, in a three-page professional-looking appeal backing 1199 in the upcoming March election. Six of the individuals – four women and 2 men – permitted the Committee to publish brief statements of their support for 1199 underneath large photos. Speaking of promotion procedures and opportunities, Jean McCallion, a middle-aged secretary in X-Ray department, stated that, at present, the Hospital does not publicize openings and vacancies to its employees. When the union

⁹⁷ "Holiday Greetings," Newsletter by 1199 Clerical and Office Employees' Organizing Committee, December 18, 1974. Presbyterian Hospital Clerical and Office Employees for 1199 Guild Representation, election date flier, February 14, 1975.

is established, “promotional opportunities have to be posted and union members have first crack at the instead of hiring from outside.” As it stood now, she said, “Presbyterian just picks whoever they want, and they can ignore experience and ability.” Larry Siegal, grandfatherly-looking cashier, said that “[a]fter half a century of working to live from one day to the next, it would be nice to have some economic security in these days of horrible inflation.” Michael Cruz, a cashier, said that 1199 will give clerical employees “better chance of advancement and do away with preferential treatment in promotions.”⁹⁸

Ronnie Roisman, a receptionist at the Hospital, told her co-workers why a union was a good and necessary thing.

Proof of why we need unions is all around us. Hospitals have their leagues and associations. Doctors have AMA. Nurses and other professional have their professional groups. Some of them disguise the fact bu calling their unions ‘associations.’ Even countries are unions of people living in common areas for their protection and benefit. George Washington and other formed a union 1776 to fight for life, liberty and the pursuit of happiness. Lincoln and the north were willing to fight and die to present their Union. They knew what a good thing the union was. We need a union to fight for and protect our interests as employees. We can join with 2,000 members already in 1199 in Presbyterian. We need 1199 now!⁹⁹

Whether the profiled members of the Organizing Committee actually said those things or simply agreed to have their name placed under pre-crafted ‘testimonials’ from the Union’s publishing office is hard to tell. But the very fact that they so readily permitted their pictures, names, and words to appear for all, including their employer and bosses, to see, was a sign of new times at the Hospital.

⁹⁸ 1199 Guild Organizing Committee at Presbyterian Hospital, “To Catch Up in Salary and Benefits We Need the 1199 Guild,” February, 1975.

⁹⁹ *Ibid.*

Unionism Prevails at P&S

With 1199's triumphant march through the heretofore impenetrable halls of the Presbyterian Hospital, the Medical School's efforts to keep 1199 out of its portion of the Medical Center became quite explicit, although hardly creative. The central pillar of this policy was laid down in a confidential memorandum from the Special Assistant to the Vice President for Personnel Management to the P&S negotiating team on the SSA re-opener in June, 1974. Mr. Rosenberg stressed that, in spite of the "unreasonable and excessive" demands made by the SSA, the negotiations should be guided by the larger goals of the University's labor relations policy. In regard to the situation at the medical school, "our goal remains to arrive at a settlement that will place the SSA in an equal or better position relative to the Local 1199 settlement on the Morningside Campus." In this regard, Mr. Rosenberg stated, the current minimum rates for P&S employees, which have been in effect since January 1973, "are completely unrealistic in terms of future recruiting needs and in terms of actual paid rates for new hires" Worse yet, "the 1199 faction in the SSA is using these figures to embarrass the University and to weaken the SSA."¹⁰⁰

Even if the salary rates rose enough to match those on the Morningside campus, cautioned Rosenberg, they would still be lower than those paid to the hospital workers under 1199 contracts. Unfortunately, Columbia made a management decision that it could not keep pace with the 1199 settlements in the hospitals because, unlike the hospitals, "the University does not have a third party to pass on the costs." Nevertheless, Mr. Rosenberg was optimistic that, if the proposed increases for the P&S employees were implemented, "the SSA [would be able to] withstand the pressure from 1199's inside organizers" as the increasingly outdated contract enters its

¹⁰⁰ David J. Rosenberg, Special Assistant to the Vice President for Personnel Management, Columbia University, to Bernis D. Moss, Jr., June 12, 1974.

last year and the pressure to reopen negotiations mounts. “This strategy,” he added, “of course, assumes that the SSA will compare their settlement to that of 1199 at Columbia, while we can expect the 1199 organizers to compare the settlement with the League settlement at Presbyterian.” Therefore, it was “essential that the SSA conduct some public relations to convey their settlement to the rank and file.”¹⁰¹

Rosenberg’s recommendations formed the basis of the University’s position in the collective bargaining agreement re-opener negotiations with the SSA and in August a new collective bargaining agreement, providing for the minimum salary rates suggested in Rosenberg’s memorandum, had been reached.¹⁰² The new contract was ratified by the SSA membership in a 507 to 80 vote, with just over sixty percent of employees voting, leaving the administration quite pleased with both the turnout and the majority.¹⁰³ The threat of 1199, however, was not exorcised for long and less than a year later the Union had again petitioned for a representation election at P&S.

In an increasingly desperate effort to keep 1199 out of the College, the Dean issued appeals to all department chairmen, saying that he “would appreciate your doing everything possible to ensure that each eligible voter is informed of our position in this union representation election.” The administration’s position was that “selection of District 1199 is not in the best interests of our employees or our School.” The Dean wrote that “[he was] dismayed by the extraordinary number of strikes in disruptive activities engaged in by District 1199 in the metropolitan area” and that “[it was his] great concern that if our employees choose to deal with a union that had a record, we face the very real possibility of loss of income to employees and

¹⁰¹ *Ibid.*

¹⁰² “Memorandum of Agreement,” Columbia University and Supporting Staff Association, August 21, 1974.

¹⁰³ Bruce E. Dalstrom, Personnel Direction, Health Science Division, Columbia University, to Putney, September 17, 1974.

interruption of the essential work of this institution.” To assist the chairmen in delivering this message, administration prepared “a number of fact sheets covering issues in the election,” as well as a closely worded letter, to be distributed to each employee, personally.¹⁰⁴

With the rapid embrace of 1199 by the semi-professional and technical workers at Presbyterian, the Union’s chances of success at P&S looked much better than at any time in the past. When the School’s supporting staff could easily compare their salaries and benefits to the union contract of the Hospital’s employees across the street or even across the hall, the public relations campaign to sell the SSA’s contract rates had poor chances of succeeding. In a representation election on October 2, 1975, P&S cast 399 votes for 1199 representation, 394 votes for SSA representation and 12 votes for neither union. It looked as though 1199’s persistence and internal support had finally begun to pay off. In a run-off election on November 12, 1975 Local 1199 prevailed over the SSA by a margin of ten votes.¹⁰⁵

Analysis of Unionization Dynamic

The unionization struggle at Columbia-Presbyterian Medical Center and its larger political context must be understood in the framework of a dual analysis of institutional and class processes. A basic duality lay at the heart of the unionization struggle. On the one hand, it was an instance of class conflict central to modern capitalist societies, concerning the determination of the market price of labor. On the other hand, the conflict was waged within and through a number of modern institutions, including the legal and political systems, as well as individual and collective institutions in the non-profit health care sector. As class conflict, the

¹⁰⁴ Donald F. Tapley, Dean of the Faculty of Medicine, to Dr. Brian Hoffman, Professor of Pharmacy, September 18, 1975; Moss to Tapley, September 19, 1975.

¹⁰⁵ Tapley to Faculty and Employees, “Results of Election,” October 2, 1975 and November 13, 1975.

struggle for unionization was conducted through class-based organizations, notably labor unions and industry associations. Its institutional sites, however, were themselves an active system of relations which created and reproduced specific class situations.

The dual institutions-and-class analysis of the unionization struggle focuses our attention on three distinct aspects of this political conflict. First, it alerts us to the complex struggle as it moved between different institutional levels, from individual hospitals to municipal administration to state and national legislatures. The nature of political settlements reached at each level reflected the changing balance of power between the elite institutions of civil society and governmental structures. Further, the dual framework allows us to acknowledge both the broadly social, class aspects of this struggle and its narrowly organizational facets and to see how political decision-making at different institutional levels enlarges or constricts the scope of social conflict and thereby affects its meaning. Finally, the institutional-and-class framework highlights the interlocking of class and social ideologies with institutional and counter-institutional discourses in the struggle over the hearts and minds of health care workers.

The struggle for unionization developed across several different institutional levels. Starting as a formally 'illegal' organizing effort at individual institutions, the struggle grew to involve several hospitals directly and threatened to spread to dozens of others. The unexpected forcefulness of the 1959 organizing drive aroused widespread concern and prompted New York City's voluntary hospitals to craft a unified front. The imminence and eventual consummation of the six-week six-hospital strike thrust the 'hospital question' into the limelight and prompted intervention by the Mayor. The conflict was formally dealt with in New York's municipal politics. In the official negotiations, conducted on the level of the city's

administration, the six hospitals were represented by the City's hospital association, while the cause of the striking workers and the union leading them was taken up by the leaders of the Central Labor Council, an umbrella organization of New York City workers' unions. Although there was a 1959 precedent, in which municipal government served as a financial broker of the hospital unionization conflict, the stronger side chose to stake the outcome on the balance of the hospitals' and the union power alone.

The hospitals' victory marked the high point of the voluntaries' unity or, at least, the effective application of group pressure by the stronger members upon their beleaguered sister institutions. Although the settlement of the 1959 strike spelled a clear victory for the hospitals, the union and its new pledges kept their struggle alive and even expanded to other institutions. Both the unexpected vitality of the 'illegal' unionization movement and pre-election political calculations created an opportunity for legislative review of the unionization issue. When, in 1962, the labor leaders obtained the Governor's promise to introduce and push the legislative amendment to the non-profit institutions' exemption from labor laws, a number of divisions emerged in the heretofore united stance of the voluntary hospitals and medical centers. The stronger hospitals, like Columbia-Presbyterian, decided that active co-operation with the Governor, rather than concerted opposition to unionization, was in their interest. For the elite institutions, as long as the law granted no automatic implementation of collective bargaining, legalization promised a relative advantage over other hospitals and a rationalized framework for anti-union struggle. For the most part, medical schools, upstate hospitals, weaker urban institutions, as well as those hospitals, where worker mobilization was already quite advanced, did not share this view.

Not surprisingly, the resulting legislation was tailored as narrowly as possible, applying only to voluntary hospitals in New York City, leaving both the upstate

hospitals and other non-profit institutions exempt. Although formally legalizing unionization of the country's largest urban hospital sector, the law effectively devolved the implementation of collective bargaining rights to the level of individual institutions and union organizations. Since the bill established no self-actuating mechanism of collective bargaining or even an automatic presumption of workers' interest in unionization, the exercise of the newly-granted rights depended in practice on when and if, in each particular institution, a union organization could prevail over the employer in an ideological struggle for employee allegiance. Given the highly disparate levels of political resources available to hospital workers and their employers, as well as social fragmentation and ideological extremism in the postwar period, it was clear that the struggle to unionize hospital workers would not be an easy one and that its dynamics and outcome would differ across separate institutions and localities.

After passage of the amendment, individual institutions became the main fields of battle, while the general structure of health care employment and careers served as the broader field of contestation. The timing, sequence, and outcome of the unionization struggle at Columbia-Presbyterian reflected both institutional and class processes at work. The late beginning of unionization was rooted in the financial and organizational strength of Columbia-Presbyterian in relation to other hospitals and medical schools in New York City, the highly conservative perspective of its privileged board, and the adroit management of legal issues and personnel relations. As organizational theory would predict, the institution's elites were the segment of its 'membership' most interested in the organization's competitive advantage. An active interest in resisting unionization on the part of organizational elites at Columbia-Presbyterian and other similar institutions was likely rooted in a more generalized interest of their class in untrammelled operation of 'labor markets.' Nonetheless, a

healthy level of pragmatism characterized their overall response, buttressed, no doubt, by the practical exigencies felt by the hospital administrators in charge of day-to-day opposition to unionism.

The Center's leadership assumed a variety of positions in this struggle. The top administrators, whose careers and reputations were closely tied to the institutions they served, were generally pro-active in union-busting campaigns. Supervisors were a critical link in the organizational chain, for whom the factors of institutional allegiance and exercise of delegated authority were tempered by the need to 'connect' with the workers, if only in order to control them. Professional staffs, especially prominent in the health care sector, proved to be another important constituency with potentially divided interests regarding worker unionization. While generally, if not uniformly, interested in holding labor costs down in the name of their institutions' competitiveness, members of professional and academic staffs were also interested in offering wage and salary rates capable of attracting well-qualified personnel. This latter interest was especially pronounced in regard to employees in various technical and laboratory assistant positions, directly involved in research and clinical work. Nevertheless, the interpenetration of professional and administrative hierarchies meant that, at the higher levels at least, professionals and academics would stand opposed to employee unions, despite the efforts of the union supporters to construct an image of generally coincident interests and a mutually supportive relationship between the professional and semi-professional employees.

When the union finally made in-roads into Columbia-Presbyterian, here, as elsewhere, the struggle shifted from non-professional to semi-professional and technical workers and now included medical schools in addition to hospitals. This new category of workers, as well as the new type of institutions where they worked place, presented new challenges which, together with Columbia-Presbyterian's general

organizational strength, were reflected in Union Local 1199's strategy. That strategy was primarily pragmatic in that fewer resources were devoted to struggles at the stronger institutions where the chances of victory were not good. Despite the establishment of a separate division for the semi-professional employees, 1199 was much less successful in organizing this category of workers.

Starting out among the semi-professional and technical employees, 1199 supporters had two major handicaps. With its militant reputation and predominantly non-professional membership, 1199 could be cast by opponents as the most extreme of several options. On the whole, the semi-professional and technical workers were less overtly exploited and, therefore, more ambivalent about open confrontation with organizational hierarchy. For them, a less notorious union or even an independent employee association could serve as a comfortable middle ground between 1199's radicalism and no union representation at all. Unionization among semi-professional employees could also be prevented through ideological or legal methods. At Columbia-Presbyterian, the route of legal contestation was taken in regard to the Hospital's twenty-four social workers, whose professional status figured, among other issues, during three-and-a-half years of courtroom battles. Ideological appeal to professionalism was likely a strong factor in the virtual absence of union interest among the Hospital's nursing staff. In both cases, the threat to the employer's power was undoubtedly augmented by professional arrogance and male chauvinism toward all-female semi-professions.

For nearly five years, 1199 had no success in breaking through the defenses of New York's largest voluntary hospital and medical center. Columbia's medical school was able to keep the union out for over six years by encouraging an independent employees association. For more than three years, Presbyterian Hospital was able to deny 1199 representation to its twenty-four social workers by dragging the

issue through the courts. Not until 1999's victory among the Hospital's 1500 service workers – to which the union had finally made a serious organizational commitment – was the door for representation of the Medical Center's employees finally thrown open. Although by the early 1970s, the rate of unionization among the semi-professional and technical health care employees was beginning to exceed that of the non-professional workers, events at Columbia-Presbyterian might be interpreted as suggesting that the surge of semi-professional unionization rested on the power of the earlier and path-breaking organization of the hospitals' lower rungs.

While 1999's breakthrough at Presbyterian confirmed the significance of the non-professional, majority minority workers' mobilization, the Union's difficult struggle at the medical school testified to a fact which the hospital boards and managements tried very hard to conceal. It showed that, despite 1999's organizational muscle, the struggle for unionization was broadly social and class-centered character and depended on the participation of large number of workers in the institutions concerned. While familiar divisions between the leaders and the led, the activists and the uninvolved were certainly present in this struggle, the story of health care unionization cannot be read in cynical organizational terms but must acknowledge its ample social sources.

The varied involvement of different employee groups at CPMC in the unionization struggle cannot be understood with either the traditional class concepts or the non-class approaches which have been proposed in their stead. While it was clearly demonstrated that the system of class positions and relations deeply conditioned the hospital unionization struggle, it is the neo-Durkheimian micro-classes which stand out as crucial elements when viewed from a close, institution-focused perspective. Institutional class positions, which anchored the varying responses of different employee groups, were determined not only by their relationship to the

means of production, but also to material and symbolic benefits stemming from occupational monopolies and organizational power. These positions, furthermore, were also affected by the specific industry, sector, and institution of employment, as well as more individual circumstances and calculations of employees. Last but not least, class positions appropriate for this analysis were clearly structured – and not merely ‘staffed’ – by the forces immanent in the systems of racial, ethnic, and gendered inequality.

Gender, for instance, was a significant but not a unidirectional factor in the unionization struggle at CPMC. At Presbyterian Hospital, an all-female social work department was at the forefront of a protracted struggle for unionization, but a predominantly female clerical unit at P&S had the highest percentage voting against representation by any collective bargaining organization. In both institutions, women in technical and service positions were as likely to be actively involved in organizing and union activities as men. By no means does this variation imply the irrelevance of gender to the determination of social processes encapsulated in the unionization drive at Columbia-Presbyterian and other health care institutions. The changing system of gender relations and inequality was crucial to the emergence of varied, yet clearly gendered occupational and organizational roles. Some of these roles, such as secretarial and clerical positions integrated female workers into organizational structures, albeit on highly subordinated and personalized terms reminiscent of gender relations in the patriarchal family. Other careers, such as social work, segregated women from men in the lower-paid, less prestigious occupational categories with an unsure claim to professionalism and its attendant perks. Still other jobs at both hospitals and medical schools preyed on the low social status of minority and immigrant women, exploiting the dual basis of that status. These different, yet distinctly feminized class locations placed their occupants in different relationships to

their superiors and employers, affecting unsurprising differences in their ability and inclination to defy organizational power in their workplace. Thus, if race and gender were frequently aligned with distinct occupational and organizational positions in the unionization struggle, their significance was exerted not in a manner of independent social determinants, external and additive to class, but as factors involved in the very construction of the manifold class locations in health care employment.

At the same time, the dynamics of the conflict studied here are suggestive of the high degree of individualization in the generation of identities, interests, and actions of the people involved. The emergence within the fairly homogeneous occupational groups of significant divisions between the leaders of the organizing drive and the uninvolved, conscious supporters of unionization and its opponents, challenges the strictly structural analysis, however nuanced. The high proportion of minorities and foreigners coupled with high rates of turnover made even the more distinct segments of the metropolitan medical center's workforce unlikely places of class-cultural homogeneity. The social dispositions of individuals who made up Columbia-Presbyterian's staff during those turbulent years, were anchored in different cultures, experiences, and worldviews, both passively inherited and actively chosen. It is certainly a testimony to the singular force of the unionization drive, as well as the larger issues of the era it tapped into, that such a high level of unity was actually achieved among as diverse groups of workers as those at Columbia-Presbyterian.

The highly personal conceptions of class interests and identity, coupled with varying empowerment to act, revealed a substantially individualized matrix of class, through which the hospital unionization struggle unfolded. Class was individualized not only in virtue of the relative weakness of common conditioning, but also due to active encouragement of individualism by institutional and social forces, with Columbia-Presbyterian's anti-union strategy as a clear example. Prodded by the threat

of unionization, the Medical Center's administration implemented an effective modern approach to personnel management. Employee affairs now had devoted to them a specific department responsible for employee procedures, complaints, and communication. The tremendous increase in contacts, between the administration and its employees fostered an impression of much more individualized, even respectful treatment. Employees were supplied with more information about their positions, their rights, and procedures and this information was increasingly systematic and precise. As far as possible, the Medical Center attempted to develop and retain its employees, through elaborated seniority and merit rules and symbolic incorporation into the system of credentialed, professional careers.

The pronounced 'individualism' of this ideological campaign strangely dovetailed with the organizational character of the unionization struggle. The Medical Center's rhetorical strategy was essentially two-fold. First, it aimed to paint 1199, as well as any rank-and-file organizing committees formed in its name, as dues-hungry, and income-maximizing. Secondly, Medical Center strove, at the same time, to suppress any discussion of *its* own status as an organization endowed with an enormous budget and supporting an extensive range of productive processes. Removing itself from the category of organizations, the employer was thus able to set up a stark dichotomy between an individual, on the one hand, and an organization, on the other. For those predisposed to buy this 'analysis,' a difficult choice was set up: either remain a free individual or be engulfed by an authoritarian and bureaucratic organization. The real occlusion here was that 'organization versus individual' may not have been the main conflict relevant to the unionization struggle and that other social conflicts, such as those of class, may have been closer to the heart of the matter.

In the highly organizational context of the hospital unionization struggle, however, the large issues of class were rarely explicitly invoked even on the other side

of the battlefield. The typically 'trade unionist' vocabulary of workers versus management or employees versus administration was consistently used and individual workplaces defined the relevant boundaries of most organizing drives. To a large extent, 1199 participated in the 'organizational,' as opposed to 'class,' definition of the struggle. This was particularly apparent in its approach to organizing semi-professional and technical employees. Aware of their sensitive relationship to professional employees and the system of credentialism as a whole, the union developed a corporatist rhetoric which celebrated the idealized notion of professional institutions and their social mission. At its most politicized, union rhetoric suggested that a union was an organization aimed at countering the power of other organizations. On the whole, however, the unionization movement did not wander too far from the concepts and vocabulary of the prevailing ideological formation. What this suggests is that the key factors in the health care's class conflict – including individualization, workplace fragmentation, and institutional autonomy – were not simply prefigured in the political development of the larger social structure. Rather, they were actively created and reinforced by concrete political organizations in a particular historical conjuncture.

The Strike of 1976 and Beyond

When unionization finally came to Columbia-Presbyterian, there, as elsewhere, it accelerated a complete rationalization of labor relations. Special administrative posts and departments were assigned to manage employee relations. Wage rates, benefits, and grievance procedures were codified and made more public. Even jobs themselves were renamed and reordered. Where earlier there had been sewing maids

and puller loaders, pantry girls and an ice cream man, there were now employees in Service categories I through V.¹⁰⁶

Negotiation of collective bargaining contracts, investigation of employee complaints and other union matters were skillfully handled through special offices in the administration and committees of the professional and academic staff. Even union strikes were taken in stride, with a set of specified procedures and mechanisms developed for this exigency. The hospital's bulletin, issued a few days before the announced strike, calmly informed the staff that "[a] Strike Control Center with a multidisciplinary staff qualified to make all necessary decisions on Hospital operations will coordinate and control activities." Things that only a few years ago were trumpeted as matters of life and death were now just inconveniences for which the staff had to be prepared for. A pre-strike bulletin for doctors with private offices in the Medical Center, for example, reminded that "[t]he following points must be kept in mind:"

No receptions or nursing attendants
No laundry deliveries. Please conserve.
No stationery or other supplies.
Personnel and doctors parking only in Main Parking Lot.
Only Main Dining room open, schedule to approximate the present one.
Live-in accommodations available on a priority basis.¹⁰⁷

By the mid-seventies both collective bargaining and strike management in New York's non-profit sector were firmly established on a city-wide scale. Local 1199 held an overwhelming majority of union contracts in the non-profit hospitals and medical centers. For their part, unionized hospitals formed the League of Voluntary

¹⁰⁶ "For Your Information," C. D. Auty to hospital employees, Assistant Vice President for Personnel, Presbyterian Hospital, February 15, 1973.

¹⁰⁷ A. Hugh Ferguson, Business Manager, Presbyterian Hospital to Attending Staff re Doctors' Offices, June 23 1976.

Hospitals and Homes of New York to conduct joint bargaining and develop common strategy on labor relations issues.

Behind the apparent rationalization and even pacification of hospital labor relations were many signs of continuing strife. Individual institutions and the voluntary hospital industry as a whole were steadily accumulating experience with unionization campaigns, as well as strategies for their thwarting. An entire niche in the consulting business emerged to take advantage of the hospitals' willingness to spend large sums of money on fighting unionization. Both New York State legislation and, especially, the 1974 amendments to the federal labor relations law concerning non-profit hospitals and health care organizations, contained multiple loopholes which hospitals could exploit to defeat or delay union elections. Institutions under collective bargaining contracts also adopted a more aggressive stance in resisting union demands for increases wages, benefits, and job security.

To a large extent, the hardening of the hospitals' positions reflected the changing political realities of hospital and health care financing. Throughout the 1960s, the drive to organize hospital workers was made easier by growing public spending on health care. In New York, municipal administration showed time and again its willingness to mediate hospital conflicts and, more importantly, to underwrite the higher wages and benefits demanded by the unions. As one of the hospital administrators recalled, during the sixties and early seventies "collective bargaining between the union and hospitals entailed little more than finding out how much the government was willing to pay."¹⁰⁸ By the mid-seventies things have changed. Increasing concern with health care costs brought both federal and state-level efforts to reduce hospital reimbursement rates. In New York, the new climate of financial

¹⁰⁸ Opinion of Norman Metzger, Mt. Sinai's director of personnel and representative of hospitals in collective bargaining negotiations, cited in Fink, *Upheaval*, p. 173.

stringency was exacerbated by the general fiscal crisis, which forced the City to declare quasi bankruptcy and come under the influence of corporate and financial leaders. In March of 1976, the New York legislature passed a law allowing the state's commissioner of health to reduce Medicaid reimbursement rates to hospitals. Since all previous negotiations between the union and the City's League of Voluntary Hospitals and Homes turned on the state's willingness to offset the cost of settlements, the new legislation held serious implications for the future dynamics of hospital labor relations.¹⁰⁹

The settlement of the 1976 hospital strike – the longest and largest in the City's history – poignantly reflected these emerging trends.¹¹⁰ During the build-up to the strike, the City's administration firmly rejected any increases in its reimbursement to the hospitals, from which to meet union's demand for wage hikes. In view of the city's new stringency, the hospital league adopted an intransigent stance as well. In an ironic twist for a militant union like 1199, the union staged its largest and longest strike ever to fight not for any concrete level of welfare for its members, but for binding arbitration which the hospitals also refused. Although an awesome display of union power, from start to finish the strike seemed to have a pessimistic tone. The strikers eventually prevailed and forced the hospitals to accept binding arbitration. The arbitrator, however, was not only convinced that no additional public funds were forthcoming, but also found no internal sources for increased wages. Even the very modest wage increase granted in the arbitration award was to be offset by cuts in the hospitals' contribution to the union's 'unproductive' educational and re-training

¹⁰⁹ Fink, *Upheaval*, p. 175.

¹¹⁰ The strike involved 57 hospitals and nursing homes and lasted 11 days.

funds.¹¹¹ Redistribution of hospitals' internal pay hierarchies or reconsideration of their investment priorities was out of the question.¹¹²

Calls for a more systematic solution to the hospital crisis, issued with some regularity since 1959, were heard with renewed frequency during the 1976 walk out. Political moderates addressed themselves to politicians and concerned social elites, calling for an overhaul of "the city's chaotic and wasteful health care system" and the creation of "a fully integrated health care system for New York that will coordinate both public and private facilities for maximum service and efficiency."¹¹³ More radical voices placed their hopes with the striking workers, urging other health care workers – doctors, nurses, and students – to support the strikes in order to form a common front against the retrenchment of health care services, which they saw as part of a "larger attack on the living standard of the people of New York" unleashed by "the Emergency Financial Control Board and the banks it represents, who are now running the City directly."¹¹⁴

Unfortunately, as federal and state governments were cutting their health care expenditures without any fundamental restructuring of health care provision, the fragmenting institutional terrain of unionization struggle was bound to become only more balkanized. When the strikers accepted the arbitration settlement 11 days after their walk-out, Byron Nichols, an attendant in the intensive care unit at Columbia-

¹¹¹ *Ibid.*, pp. 175-180.

¹¹² It must be noted that 1199 itself did not question either the general salary and income structure in health care or of hospital management and health care organization and financing as a whole. For an extent of the Union's rhetoric on these issues, see "Sez Hospital Brass is Gold," *Daily News*, July 26, 1976. In this article, Moe Foner, 1199's executive secretary, is quoted charging that hospitals provide many and lavish benefits to their administrators and doctors, while claiming that they are absolutely unable to raise wage rates for their non-professional workers. A call on hospitals to "open their books" was a frequent one but hardly effective in changing the overall hospital and health care income structure. For critiques, see Ehrenreich and Ehrenreich, "Hospital Workers: Class Conflicts in the Making" and Langer, "Inside the Hospital Workers' Union."

¹¹³ "Hospital Non-Solutions," *New York Times*, June 25, 1976; "Health Services Emergency," *New York Times*, July 23, 1976.

¹¹⁴ "Its Our Battle Too!" a flier issued by the Medical Committee for Human Rights, undated.

Presbyterian, told the newspaper reporter that he was “elated” that the strike was finally over but thought that “hospital workers will always be underpaid in capitalist society.” At another hospital, a weary hospital administrator complained how hard it was to run a non-profit hospital under prevailing reimbursement rates. “There is no fat in this hospital,” he added, “but the strike [proved] there are some areas where we can make do with a lot less (sic) people.”¹¹⁵ That was indeed one of the main ways, in which the hospitals would try to balance their books over the next decade.¹¹⁶

¹¹⁵ “Hospital Workers Return As Longest Strike Ends,” *Heights-Inwood*, July 21, 1976; hospital representative quoted was Charles Gellman, executive director of the Jewish Memorial Hospital in Bronx.

¹¹⁶ Fink, *Upheaval*, p. 178.

CHAPTER 7

ORGANIZATIONAL POLITICS OF VOLUNTARY REFORM: THE COMMUNITY HEALTH PLANNING INITIATIVE, 1970-1976

Introduction

There has been a long tradition in American politics of achieving public goals by stimulating private and voluntary initiative. American health care presents one of the more conspicuous examples of such a mixed, public-private approach to social provision. The period between the early 1960s and the mid-1970s, during which a cluster of issues under the rubric of 'community health planning' predominated in both public policy and private efforts, was no exception in this respect. Vague yet evocative, community health planning pointed toward a voluntary effort to rationalize the predominantly private system of health care provision, conducted through a partnership between community leaders and representatives of hospital, medical, and other relevant groups. Representatives of private non-profit health care institutions played an important role in the formulation of governmental policy and public policy, in turn, encouraged predominantly private and voluntary planning efforts.¹ An explosion of social protest and grassroots organization, which marked this period of American history, set the community health care movement apart from more placid periods of elite and interest group politics. Both politicians and private institutions had to contend with protest-bound citizenry, grassroots organizing, and new community leaders pressing for reforms in health care delivery.

¹ For a brief discussion of the major federal health care legislation during this period, see Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982), Book Two, Chs. 3 and 4; Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*, (Baltimore: The Johns Hopkins University, 1999; New York: Basic Books, 1989), Chs. 10 and 11.

Located amidst the rapidly declining urban areas, Columbia-Presbyterian Medical Center and its parent University were abundantly subjected to all those pressures which contributed to the perception of crisis in the American health care system. Appalling conditions in hospitals' outpatient clinics, rising protests among students and staff, and the waves of ghetto riots were all signs of deepening problems. Nevertheless, auspicious conditions for an institution-wide response to these pressures did not arise until 1970, when Columbia's Medical School underwent a significant changing-of-the-guard in its top administrative and academic positions.

Nearly two years elapsed between the early discussions and the launch of Columbia's community health initiative.² During this time, what appeared at the outset as a spectrum of progressive ideas turned into an essentially conservative, limited, and technocratic proposal. The founding assumptions and choices underlying Columbia's Center for Community Health Systems (CCHS), which became the initiative's primary organizational form, inclined the initiative toward instrumental, contractual, and private relationships with external institutions, and against broader and genuine alliances. Not surprisingly, the Center's efforts to engage the affiliated hospitals were complicated and largely unproductive, while its relationship with community groups did not progress past suspicion and conflict. After the middle of the decade, the Center was conspicuously reorienting itself toward a new 'movement,' health services research. This new field was a good bet, an area of research that would survive and grow. As an outgrowth of the community health movement, however, it

² Over the course of its conceptualization and establishment, the name of the project changed twice: first from 'Office of Health Care Planning' to 'Office for Research and Planning of Community Health Systems' (ORPCHS) and then to 'Center for Community Health Systems' (CHSS). To avoid confusion, the term 'initiative' is used throughout the chapter to tie together the different names of the evolving project and to emphasize that the name, as well as the organizational form, of Columbia's involvement in 'community health planning' were subject to contestation and change. 'Community health planning initiative,' 'community health initiative' and 'Columbia's initiative' are used interchangeably throughout for readability.

signified the final abandonment of those aspirations which the word ‘community’ both evoked and disguised. By the end of the 1970s, the Center was moved to the School of Public Health: community health planning was no longer a concern of the Medical Center as a whole.

As the larger period in the American health care politics of which it was a part, Columbia’s community health planning initiative can be viewed as a loss of a liberal opportunity.³ Why and how was this opportunity lost? Existing analyses of this period in American health care politics emphasize institutional fragmentation of the health care sector and the largely symbolic nature of the American democratic process.⁴ These explanations, however, reveal only part of the story, focused on the inter-institutional and formal-political levels. From an intra-institutional perspective, such as the one taken here in regard to the politics of one of the nation’s oldest and largest academic medical centers, the answer includes organizational and occupational power structures, operating both within individual institutions and across the larger matrix of American medicine and health care.

Early Visions and the Power Struggle

The earliest reflections pertaining to Columbia’s community health planning initiative articulated three views on what should be done and how it could be accomplished.⁵ All three perspectives had in common an insistence on doing something practical to contribute to solving the problems plaguing the American

³ The characterization of this period as one of “liberal opportunity” is from Starr, *The Social Transformation of American Medicine* p. 363 and Chs. 3 and 4 of Book Two more broadly.

⁴ See, for example, James A. Morone, *The Democratic Wish: Popular Participation and the Limits of American Government* (New York: Basic Books, 1990), Ch. 7; Starr, *The Social Transformation of American Medicine*, particularly Book Two, Chs. 3 and 4; and Rosemary Stevens, *In Sickness and in Wealth*, especially Chs. 10 and 11.

⁵ Unless otherwise noted, all information pertaining to Columbia’s community health planning initiative comes from the Health Sciences Division Archives, Dean’s Code 190, folders labeled “Center for Community Health Systems (CCHS)” spanning the period between 1970 and 1976.

health care system and all three insisted that the way to start was to change the way of ‘doing business’ at the Medical Center. Despite their common tone of resolve, the views differed on how the needed change could be brought about.

One view put forth an essentially technocratic vision of the process, where the necessary changes were to be implemented through competent analysis of the problems, cogent proposals to correct them, controlled experimentation, and inter-institutional borrowing of winning models. Describing the mission of the proposed office for health care planning, one early communication suggested that “[i]ts purpose would be to propose change in the way of doing business, support these proposals with rational arguments to allow estimates of the costs and benefits, and provide a proposed schedule and means of the evaluation of the change.” In this way it would be possible “to have a progressive package which could be understood and approved by the personnel of the participating hospitals and by the Board of Directors.”⁶

The second position on the emerging initiative advocated the establishment of a new academic and professional field in ‘community medicine.’⁷ Noting a growing movement among the medical schools in this direction, this view presented community medicine as a field that would shortly become indispensable to medical practitioners and the system of health care provision as a whole. This view’s proponents helped that development of this new field could contribute significantly to solving current problems in health care provision. Increasing teaching and research efforts in primary care settings would serve as the medical schools’ immediate

⁶ Richard L. Garwin, IBM Fellow, Columbia University to Dr. Robert Glaser, Dean of Medical School, Stanford University, Stanford, CA, April 6, 1970. In another revealing line, the author insisted that if “the development of health care is going to advance at all, most of the ‘innovations’ ... will be largely copying of what has been established elsewhere and not a true experiment.”

⁷ The Office of Urban and Community Health Affairs, George I. Lythcott, M.D., Associate Dean, “Community Medicine: A Study of Several Medical School Programs in the USA,” submitted by Bernard Challenor, M.D., Judith Wicks, B.A.

contribution to improving community services, while the training of future doctors in community medicine would exert a long-term effect on the nation's health care system.

The third and, arguably, most radical view presented a political understanding of the problem, arguing for the need to alter the structure of power and prestige within the Medical Center and academic medicine as a whole. "The Trustees," insisted its proponent, "must be willing to commit themselves to a total reorganization of health care delivery at the Medical Center during the 1970s" aimed at creation of an essentially one-class system of care.⁸ This goal could hardly be achieved, however, if the practice of general community medicine remained the least prestigious and rewarded of medical fields. One-class health care required medicine that did not have its own professional underclass. The task, then, entailed a redistribution of prestige and rewards from private specialized medicine to community primary care.

While this explicitly power-centered analysis of the problem was a distinguishing characteristic of the last perspective, all three proposals included elements of political understanding of the community health planning movement. The 'technocratic' perspective, for instance, was explicit that, within the medical centers, community health planning was a cause of the more progressive elements and would likely arouse resistance from those with vested interests in the current system. Fortunately for Columbia-Presbyterian, in early 1970 "there [were] 14 departmental chairmanships and key staff positions vacant in the medical complex," which meant that "the College [did] not have at this moment precisely the same problem of strong

⁸ "Privileged Communication," undated, probably Spring of 1970. Although unsigned, the document can be attributed with high certainty to Dr. Robert E. Canfield. The strongest evidence of his authorship is provided by an almost identical discussion of a plan for reorganization of health services at the Medical Center that appeared in Dr. Canfield's correspondence (Canfield to Henry Aranow, Acting Chairman, Department of Medicine, August 13, 1970, Appendix pages 13 and 14.) and is also suggested by the general views expressed in his numerous letters and documents.

departmental interest interfering with progress toward the development of health care.”⁹

The ‘community medicine’ view was also importantly premised on the understanding of the political context, from which the new field stemmed. The study, in which it was laid out, pointed to students and communities as primary forces compelling the universities’ response. “A sizeable and increasing number of medical students,” the study noted, “feel that the medical profession and medical schools have been unresponsive to the real needs of their patient populations, and particularly those in poverty area,” and “rightly resent the continuation of a dual system of health care, one for rich and another for the poor.”¹⁰ Rising protests among the urban poor were another factor compelling initiation of community medicine programs. “Residents – particularly those living in lower socioeconomic areas adjacent to medical schools – have clearly voiced their dissatisfaction with the treatment they receive in teaching hospitals and with the medical schools’ disregard for their own needs.” Medical centers, urged the study, had to find some ways to begin to “resolve these antagonisms.”¹¹

⁹ Garwin to Glazer, April 6, 1970.

¹⁰ “Community Medicine,” p. 66-67.

¹¹ *Ibid.*, p. 67. It is not unreasonable to think that the deeper personal views underlying these three positions were closer than written articulations suggest, since they were communicated in different formats and to different audiences. In fact, the degree of political boldness expressed in a given position was inversely related to the confidentiality of the document, in which they were communicated. The ‘political’ view was laid out in the unsigned, highly confidential memo. The ‘technocratic’ view was spelled out in a letter addressed to the Dean of another medical school. The ‘community medicine’ position was developed in a study of such programs in medical schools across the country that was likely intended for broad internal circulation within the medical school and the university as whole. Thus, it is possible that Dr. Lythcott’s personal views were more radical than the study let on or that Dr. Canfield’s position would inevitably have to be ‘toned down’ or ‘camouflaged’ for the purposes of more public dissemination. It is also possible, of course, that the differences between the positions were based on divergent assessments of the situation, in which the initiative would have to be launched. More hopeful and radical positions, expressed in the ‘political’ and ‘technocratic’ perspectives may have been undergirded by certain assumptions, such as the continuing pressures for health care change from the side of the government or consumers or both. The ‘community medicine’ perspective, in contrast, may have assumed a different estimate of the balance of forces within the academe, which dictated a less conflictual approach.

Consideration of external political forces was thus present in all three early views. Whether the solution advocated entailed rational planning, academic recognition, or an institutional shake-up, both the emergence and future success of community health movement, they were saying, depended on sustained pressure in the larger polity. All three views implicitly acknowledged that university ‘liberals,’ pushing for community health planning, had important ‘allies’ outside of the academe, including the students, poor and minority groups, and progressive professionals and public figures.

Unsurprisingly, the academic ‘progressives’ calling for community health planning occupied somewhat peripheral positions within the structure of the academic medicine. The ‘technocratic’ view, for instance, was articulated from a position outside of the Medical School proper, reflecting a growing interest of the academics in various liberal disciplines, as well as certain professional fields, such as business, social work and urban planning, in health care issues. These academic interests were still rather undeveloped and did not command resources and recognition comparable to those of the traditional bio-medical and clinical disciplines.

The ‘community medicine’ perspective, emanated from the recently created Office for Urban and Community Health Affairs, headed by Dr. George I. Lythcott in the position of Associate Dean. Although formally recognized as being at the top of the medical school’s administrative structure, Dr. Lythcott’s position was actually at some remove from the most prestigious and powerful areas within the Center’s organization. Dr. Lythcott held a clinical appointment at the Harlem Hospital, one of the several public institutions that P&S was affiliated with, and such appointments were both less prestigious and less lucrative than those at Presbyterian or other private affiliates. Arising, as it had, from an institutional location in an affiliated public hospital, which was both geographically and organizationally removed from the

medical school's center, Dr. Lythcott's Office had effective 'jurisdiction' primarily over Harlem and other public affiliates. The heart of Columbia's medical center, the Presbyterian Hospital, as well as its other private affiliates were unlikely to come under its influence and direction.¹²

The third, 'political' perspective was rooted in the professional frustrations of physicians providing ambulatory and emergency services at the urban academic medical center, a problem with which its chief proponent, Dr. Robert Canfield, was very familiar and which he and a group of his colleagues tried to address for several years. Starting in the late 1960s, the group tried to alarm both the Hospital and School administrations that the situation in the outpatient clinic "has reached a deplorable state in which the practice of medicine is conducted in a poor fashion that sometimes borders on malpractice." The immediate reason was that, over the past decade, the number of patients presenting themselves at the outpatient clinic had grown dramatically, while the level of staffing, as well as mechanisms of accountability, had deteriorated. In the group's opinion, it was "unethical to subject patients to medical care as it is presently being delivered in that area."¹³ Dr. Canfield and his colleagues were well aware that outpatient medicine was completely shorn of the trappings of professional prestige compared with other branches of academic medicine. It generated less income, served lower socio-economic groups, had inadequate facilities, and attracted little or no research funding. Those who served or headed ambulatory

¹² City-owned Delafield Hospital was another hospital with which Dr. Lythcott's office was expected to be directly concerned. Conceivably, two smaller voluntary hospitals – St. Luke's and Roosevelt – with which P&S had affiliation contracts, might have also become sites for several activities pursued by Dr. Lythcott's office but that was still unclear. What seems clear is that the Presbyterian Hospital was not subject to any considerable influence and direction of the Office of Urban and Community Affairs, the fact which indicates its de facto marginality within the organizational structure of the Columbia-Presbyterian Medical Center.

¹³ "Resume of November 3rd and November 10th meetings," November 14, 1967 ("Present: Doctors Buchanan, Canfield, Kimberg, McConnell and Neu."); Canfield to Aranow, August 13, 1970.

departments also did not have institutional power comparable to heads of other departments and thus had little capacity to improve the situation.

Although situated in the marginal domains of academic medicine, during the late 1960s and early 1970s, Columbia's 'progressives' were in a more powerful position than at any other time in past two decades. The wave of social upheaval had reached inside the urban medical centers and many, including Columbia-Presbyterian, were undergoing significant change in their upper echelons. Both the vacancies and the new appointments reflected a new political climate surrounding academic medical centers and the new leadership was considerably more open to the need for change.

If the early reflections on community health care problem might have suggested that Columbia's 'progressives' had a common cause, a personal conflict that emerged early in the process of planning shattered this impression. In the spring of 1970, Dr. Canfield was allegedly offered the leading role by the new Dean.¹⁴ The preliminary understanding was that the initiative would be: (1) established as an Office of Health Care Planning, (2) attached to the Office of the Dean, and (3) headed by a new position of an Associate Dean for Health Care Planning. Dr. Canfield accepted, albeit with some reluctance, related more, as he recalled, "to the vagueness of the situation than to any lack of personal commitment."¹⁵

On May 20, 1970, Dr. Canfield presented his first proposal for Columbia's community health planning initiative at a small meeting. (See Figure 7.1.) At the center of Dr. Canfield's early proposal for the structure and functions of the Office of Health Care Planning was a Division of Medical Methods Research.

¹⁴ Canfield to Paul A. Marks, Dean, College of Physicians and Surgeons, Columbia University, June 11, 1971.

¹⁵ *Ibid.*

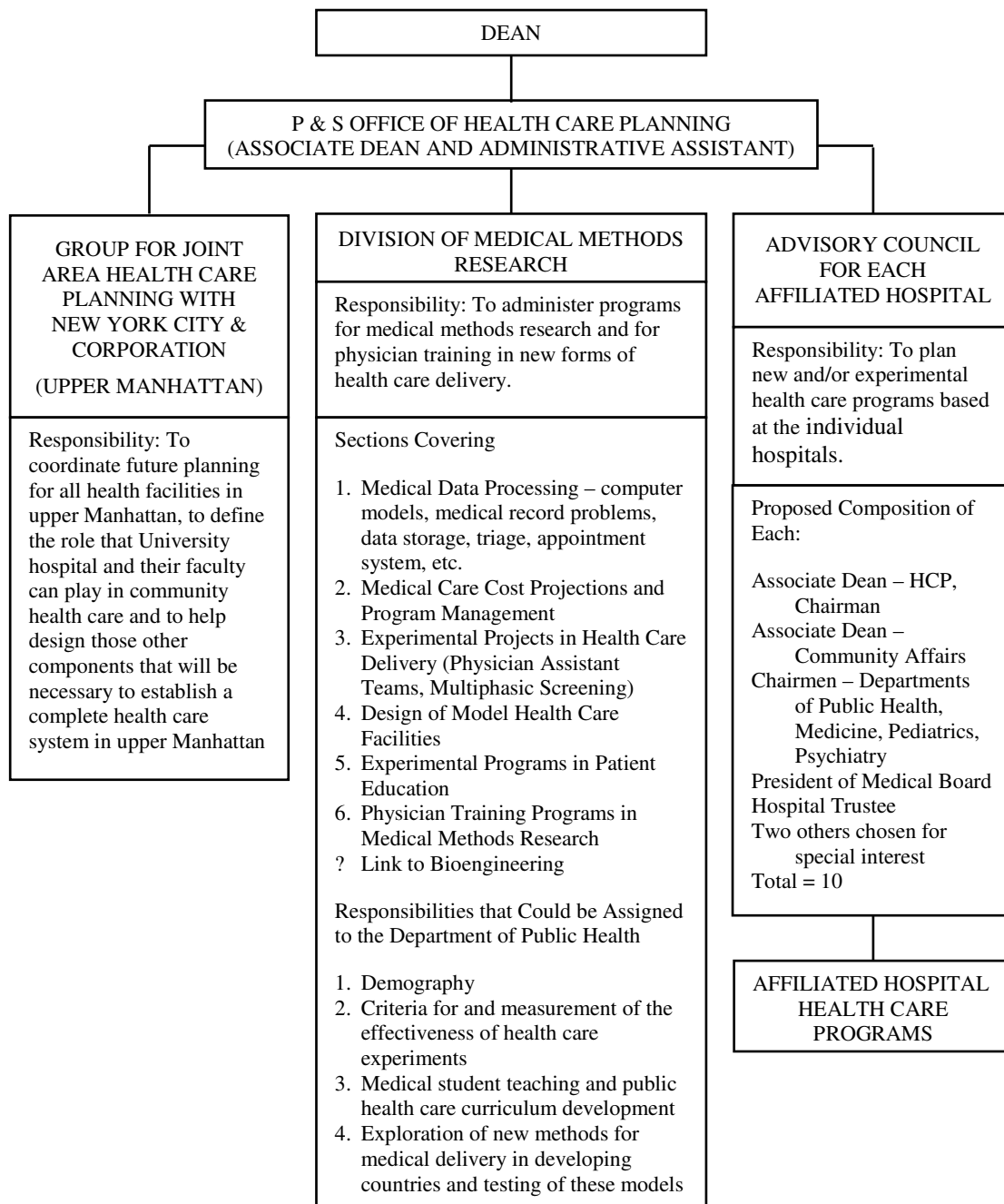


Figure 7.1. Original Organizational Schema for Columbia's Community Health Planning Initiative Proposed by Dr. Canfield. *Source:* R. E. Canfield, Proposal, 5/19/70, attached to Canfield to Marks, May 20, 1970.

The Division was conceived as a broad new field of research and teaching, centered in and around ambulatory care, with additional involvement of the Department of Public Health. As might have been expected, Dr. Canfield's proposal thoroughly 'camouflaged,' if not altogether submerged, his earlier more radical (and confidential) views. On its face, the proposal did not suggest any direct restructuring of the professional and academic hierarchies, nor the reallocation of resources from the private patient care to community health services. Of course, the creation of a new academic division, centered on ambulatory care, was related to his earlier insistence that ambulatory care must be re-created as a respected and well-supported field of research and teaching. The proposed 'hospital councils' were also conceivably related to his earlier position on changes necessary at Columbia-Presbyterian. Dr. Canfield's proposal, then, seemed to retain some of the *means* from his earlier position, even as its *ends* were now moot.

At the meeting, both Dr. Canfield's organizational scheme and his personal qualifications for leadership came under vigorous attack from Dr. Lythcott. His most frequent objection to Dr. Canfield's scheme was that it bore no relationship to the Office of Urban and Community Affairs office and/or proposed to duplicate and usurp that Office's established functions.¹⁶ Worse than that, in Dr. Lythcott's opinion, was

¹⁶ While no official record of the meeting's discussion can be found, the substance of Dr. Lythcott's attack could be gleaned from a memo outlining his criticisms of Dr. Canfield's proposal written a day after. ("Confidential Draft," Lythcott to Marks, attached to "Proposal, R. E. Canfield, 5/19/70;" both attached to a handwritten note, dated September 10, 1970, from Lythcott to Fred [Putney, Assistant Vice President in Charge of Medical Affairs, Faculty Medicine, Columbia University] with a note: "Fred – I found this rummaging (sic) through some old correspondence. Tennis anyone!") It appears that this letter had not been sent, but it is reasonable to assume that it outlined precisely those criticisms which Dr. Lythcott directed at Dr. Canfield during the meeting. Apropos the 'Affiliated Hospital Health Care Programs', Dr. Lythcott said that "[t]his chart shows no relationship to me or my office." Regarding the 'division of medical methods research,' he protested that "even in this extremely delicate area there is no organizational or administrative relationship to me or my office." About the 'joint area health care planning and corporation,' he said that "[t]he corporation has already appointed a task force to develop comprehensive systems or patterns of health care development and planning under the direction (chairmanship) of Dr. Van Dyke of the School of Public Health." Moreover, "my office is

that “Canfield has carved out for himself a niche in Health Care Planning, with no regard for broad based community health programs, maximizing the skills he does possess in a very small part of the equation, and minimizing and usurping the input of others who have considerably more experience, knowledge and expertise in this much larger equation of community medicine and health.” Judging the proposal to be “a disaster,” Dr. Lythcott saw “no *total* role for Canfield in this area of Community Medicine *except* in the area of the division of Medical Methods Research as an arm of and resource person to the Chairman of the Department of Community Medicine, and clearly under the direction of the Chairman.”¹⁷

Following the meeting, a new organizational schema appeared in the Dean’s files, dividing the coming ‘kingdom’ of community health planning in two. (See Figure 7.2.) In contrast to Dr. Canfield’s chart, where the direction over the proposed initiative was centralized under an Associate Dean for Health Care Planning, the new organizational structure was centralized only under the Dean of the Medical School and the Vice President for Medical Affairs. Otherwise, it was a dual structure, split between the Office of Health Care Planning, presumably headed by Canfield, and the

already working actively and meaningfully with this task force” and Canfield’s schema “completely ignores this already developed fact of our lives.”

The severity of the criticisms is consistent with the impression Dr. Canfield received from the meeting and recorded in his letter to the Dean. (Canfield to Marks, May 20, 1970.) “I thought this morning’s meeting was extremely useful,” he wrote diplomatically, “and brought to the surface a number of matters that I have sensed as problems and that you must resolve.” In particular, it became clear that “George [Lythcott] has great opposition to me and the approaches I represent.” The feeling that Dr. Canfield took away from the meeting was that “[he] clearly [was] not the man for the job at this time” and asked the Dean not to introduce him in any official capacity at the upcoming public meeting. He said he would also “bow out” of the job of planning the physical reorganization of the ambulatory clinic, as soon as the Dean found someone else to do it.

¹⁷ *Ibid.*, emphasis in the original, via underline. Dr. Lythcott’s own preferred organization of the new initiative – Department of Community Medicine – did not have a broad support either because the Dean and several other figures involved expressed the notion that, to be successful, the community health care initiative had to be an overarching, inter-departmental activity, rather than a function of any one department. (Marks to Bryant, December 28, 1970.) For the most part, then, Dr. Lythcott’s vigorous opposition to Dr. Canfield had an effect of acknowledging the prerogatives of his Office of Urban and Community Health Affairs in the evolving plans.

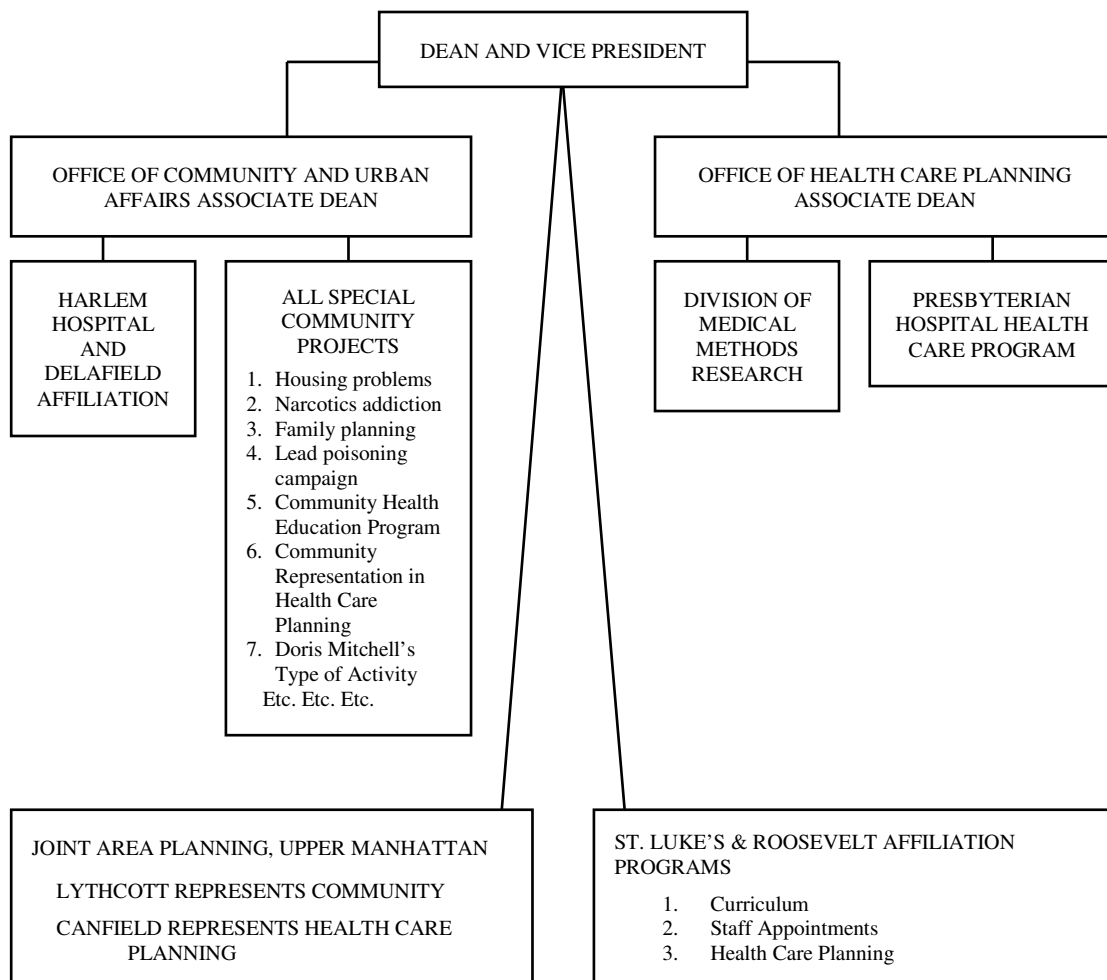


Figure 7.2. Revised Organizational Schema for Columbia's Community Health Planning Initiative Intended to Attenuate the Conflict between Drs. Canfield and Lythcott. *Source:* Attachment to Canfield to Marks, May 20, 1970.

Office for Urban and Community Health Affairs, headed by Lythcott. In view of the deep personal conflict, even some of the clearly joint functions were parceled out between the two. In the 'joint area planning,' for instance, Lythcott would be concerned with community, while Canfield would focus on health care planning. The two voluntary hospitals, with which the School hoped to strengthen ties, were also 'divided' between the warring parties, with one arrow pointing from the Roosevelt Hospital to Lythcott and another from St. Luke's going to Canfield.

It was in this tense and uncertain atmosphere that the planning of Columbia's community health initiative continued over the summer. Dr. Canfield's thinking, conveyed in several drafts of a proposal he was working on, appeared to further retreat from his earlier radical position. In contrast with his earlier communications, the community health planning initiative was now presented as a sort of conflict-free, School-wide undertaking, rather than a problem the solution to which would have to impinge on some of the vested interests within the medical faculty. The role of the university medical faculties was now glorified and elevated over that of other social actors. At present, read one of his drafts, "[m]ost of the policy decisions that concern health care planning in this country ... are being made by politicians and administrators" who "may accept short term solutions that significantly compromise the professional excellence that University hospitals must maintain in the future."¹⁸ If universities failed to provide leadership, they "may be compelled to accept disagreeable policy decisions made by public agencies and it is unlikely that these agencies will act in concert with what the University believes to be the proper priorities." The medical faculties' preeminence, argued Dr. Canfield, had its foundation in their historical record as "the ethical, if not the political leaders in medicine," quite a stretch from an individual who had just recently declared that Columbia's medical faculty allowed the outpatient clinic under its professional control to reach "a deplorable state ... [bordering] on malpractice."¹⁹

The new drafts also directly repudiated Dr. Canfield's earlier view that any serious change in health care access necessitated a redistribution of power and prestige within the Medical Center and medicine at large. On the contrary, conscious

¹⁸ Robert E. Canfield, M.D., "Confidential Private Copy," undated.

¹⁹ *Ibid.*; Canfield to Aranow, August 13, 1970.

preservation of the existing organizational structure was recommended. “At the present time,” he wrote,

our faculty is largely composed of two groups: a full-time salaried staff that devotes its principal attention to fundamental research problems and a clinical faculty that sustains itself by devoting its principal attention to the private practice of medicine. Ideally, and practically, both groups are performing their needed functions well and it would be unreasonable to suggest a dramatic alteration in the level of support for the professional “way of life” for either group. Thus the first principle of health care planning at the University will be that new programs should be largely staffed by new, younger, faculty members who are specifically recruited for these programs.²⁰

To his credit, Dr. Canfield still insisted American health care was in crisis and that, over the next decade, academic medical centers would have to adapt to “a social revolution which is asserting that every individual should have equal access to excellent medical care.” This transformation, however, appeared no longer linked to any fundamental restructuring of academic medicine’s power structure.

While the outcome of the feud between Drs. Canfield and Lythcott remained uncertain, another figure interested in the leadership of Columbia’s community health planning initiative appeared on the scene in the middle of the summer, in the person of Dr. John H. Bryant, who accepted a position of the Associate Dean of the School of Public Health and Administrative Medicine.²¹ As with Drs. Canfield and Lythcott, Dr. Bryant’s new position in the organizational matrix of the Medical Center and academic medicine at large was at some remove from the true centers of money, power and prestige. Marginalization of public health in favor of private medicine and of preventive medicine in favor of therapeutic methods was a long-established socio-

²⁰ Canfield, “Confidential Private Copy.”

²¹ Report of the Vice President in Charge of Medical Affairs and the Dean of the Faculty of Medicine, CPMC Annual Report 1970. Prior to his appointment, Dr. Bryant served as a director of programs in health care delivery at the Rockefeller Foundation and his recruitment to Columbia was clearly linked to the evolving initiative.

political fact in American health care. At Columbia, this fact was institutionally expressed in the de facto subordination of the School of Public Health to the medical school, as well as highly disparate resources of the two schools.²² Like other proponents of community health planning, those in the field of public health hoped that the current crisis in American health care might increase resources and prestige accorded to their field. Public health faculty could claim, and quite justifiably so, that community health care belonged to the intellectual heritage of their discipline and that its goals were closely linked to the need to correct the woeful neglect of public health in favor of private medicine.²³

While Dr. Bryant was still away, a small group of individuals who were most closely involved with the community health initiative, gathered for a planning conference at Martha's Vineyard on August 9, 1970.²⁴ Among those present was Dr. Eli Ginzberg, then Professor of Economics at Columbia University School of Business and Director of the Conservation of Human Resources Project. As someone already actively engaged in policy-relevant health care research, Dr. Ginzberg's involvement reflected a growing interest on the part of many academics outside of medical schools in problems and issues pertaining to health care. Not surprisingly, Dr. Ginzberg was an advocate of including faculty from the social sciences and other non-medical disciplines in Columbia's community health planning effort.²⁵ Along with the other

²² The School of Public Health, for instance, did not have its own Dean but only an Assistant Dean subordinated to the Dean of the Faculty of Medicine. (Columbia-Presbyterian Medical Center, Combined Annual Report 1970.) Although formally a separate school, public health had a status of a department, and not a favored one at that.

²³ In May of 1970, there was issued a 38-page "A Discussion of Columbia University's Role in Public Health," prepared by the School of Public Health and Administrative Medicine. The document discusses at length the history, activities and resources of the School, with a special emphasis on the unmet needs of the School which hampered it playing a more useful role.

²⁴ "Notes on Conference on Community Health Services Program for P&S," Rough Copy, undated. ("In attendance were Drs. Eli Ginzburg, (sic) Lang Burwell, Fred Putney, Robert Canfield, George Lythcott and Paul Marks.")

²⁵ *Ibid.*, pp. 12-13. Mrs. Nora Piore, for instance, who would become one of the Center's principal investigators, was recommended by Dr. Ginzberg.

figures in the University, Dr. Ginzberg saw the early 1970s as an opportune time to introduce substantial changes in the University's relationship to the medical center and the medical center's relationship with the community.²⁶ Overcoming the medical school's traditional aloofness from the rest of the university – both in institutional and epistemological terms – was a major part of this task.

At the conference, realistic goals and a pragmatic approach took center stage in the discussion and Dr. Ginzberg's input, in particular, appeared to be the voice of caution. According to the transcript of the meeting, a recognition was urged that "one can not force a pattern on a group of physicians or consumers" and that, in planning for improved community health care, "one must start with the existing facilities, personnel and consumers."²⁷ The task was to "use the present system, but at a higher level of productivity."²⁸ The conferees felt that "perhaps the most novel aspect of a Community Health Service Program to be developed at P&S would be the effort to put together a program with the existing physician-patient relationships in our Community and the potential resources of the University-affiliated hospitals." Such an approach would be different from and superior to other initiatives in the country. It would avoid the pitfalls of the Harvard Medical Plan, which conferees felt "attempted to create a wholly new fabric of health care delivery services and ... sell it to the community as a program super-imposed on the existing health care delivery programs in that community." It would also differ from the Kaiser Permanente model, where "consumer-doctor relationship were not incorporated and used as a base for improving health care delivery."²⁹

²⁶ Garwin to Glazer, April 6, 1970.

²⁷ "Notes on Conference," p. 8.

²⁸ *Ibid.*

²⁹ *Ibid.*, p. 7.

The question of whether the medical school could contribute significantly to developing new, community-oriented forms of health care was addressed only in regard to requisite resources. An attempt to “catalog the major facilities available to P&S with respect to potential in a community health services program” yielded, as top items, the several private and public hospitals affiliated with P&S, boasting impressive numbers of beds and staggering patient loads. However, all of these hospitals were, in fact, independent institutions, staffed but hardly controlled by the medical school and its parent universities. The jewel in the Columbia’s medical crown, Presbyterian Hospital, was the most problematic of all. Even during the most hopeful, early stages of planning, it was largely concluded that Presbyterian could not be counted upon for participation in community health planning in the near future. The most promising hospital, at the time, was Delafield, a municipal facility with bed capacity equal to one eighth of that of Presbyterian and with no outpatient department.³⁰

The view that the community health planning initiative should not fundamentally change the ‘way of life’ of currently practicing physicians was also affirmed. Whatever initiatives were to be undertaken at Columbia, it was hoped that “particularly the younger members of our staff might be interested in becoming involved in the Program.” Along with young doctors, it was also “appropriate, indeed imperative, to begin by developing mechanisms for involving non-affiliated community physicians in a mutually beneficial, dignified, and meaningful manner in the health services system.”³¹ The new ‘community’ physicians were to be backed up by an expanded paraprofessional labor force.³² For obvious, albeit unstated reasons,

³⁰ “Notes of Conference,” pp. 3-4.

³¹ *Ibid.*, p. 6.

³² In order to cut the costs of community health services, the planners agreed that “[a] heavy emphasis would also have to be placed on incorporating allied health professional man-power output into this program.” They stressed, however, that the incorporation of greater number of “paramedicals” should

the Center's traditional staff could not be expected to provide the kind of services which make up the bulk of community medicine idea. The actual work of community medicine would have to be done by people other than and different from those currently associated with the Medical Center.

The main message of the conference was to avoid 'over-promising' and "to stay close to the present realities of health care delivery from the point of view of the consumer as well as the deliverer." Dr. Ginzberg in particular argued that the approach should be "one that [aimed] toward a less ambitious but more replicable program."³³ In his own summary of the conference, he reiterated the need to limit the scope of the initiative and avoid assuming actual responsibility for providing health care services to a specific population. "The word comprehensive should not be used," he counseled, "an expanded, improved community health service program is broad enough." It would be easier to "try to put together part of the total package by linking patients and physicians now organized in HIP; taking in families with Blue Cross and Blue Shield and/or GHI and selling them some supplemental coverage; getting a group of welfare cases paid for by the city rather than to go out and sell brand new coverage." Noting the growing interest of the private insurance companies, Dr. Ginzberg thought it "desirable to map in one or more private insurance companies to experiment with new forms of insurance for ambulatory services."³⁴

The overall vision that emerged during the conference was both conservative and marginal to the core structures of Columbia's medical empire. At the most, what it implied was redeployment of the bottom twenty percent of physicians within the

be accomplished "without it involving any significant net loss of income to physicians." ("Notes on Conference," pp. 11, 10.)

³³ *Ibid.*, p. 1.

³⁴ Eli Ginzberg, "Memorandum for Paul Marks, Subject: Planning for Health Care Delivery System," August 20, 1970.

new community health care practice, along with the infusion of additional unaffiliated and paramedical personnel, while the existing organization and levels of income for the top eighty percent of the medical profession were preserved. All of the change was to be concentrated at the bottom of the professional pyramid, the base of which could be lowered, in terms of power and income, and expanded by recruitment and training of personnel drawn from the lower socio-economic groups. The bulk of the professional edifice would be left untouched, in the foreseeable future at least.³⁵

Significantly, however, the project under discussion was still an actually functioning program of health care services.³⁶ In fact, the theme of caution and pragmatism, sounded particularly by Dr. Ginzberg, appears to have been genuinely motivated by a desire to see Columbia's initiative actually embodied in a working program of community health services, rather than remaining on the level of theory. Although the program was contrasted with Harvard's and Kaiser-Permanente, the contrast was not between service and research projects, but between different concepts of actually functioning programs.

³⁵ The emphasis on utilizing younger and so-called community physicians (i.e. local practitioners without university affiliations) – as well as the need to do so in a 'dignified' manner – was only a thinly veiled suggestion that community health services would have to be rendered by physicians willing to accept, for lack of better options, considerably lower incomes and less prestige than those in either private practice or academic medicine. In the urban areas, the least prestigious medical practice was fast becoming a preserve of foreign medical graduates, many from rapidly growing Third World economies like India and the East Asian countries. (See Starr, "The Social Transformation of American Medicine," p. 363.) If American minorities could be admitted to medical schools in greater numbers, while facing discrimination in professional practice, they, too, could be candidates for practice in urban 'ghettos'! Third world doctors for second-rate citizens of the first world country! While vehemently opposed to acceptance of foreign medical graduates, American medical profession clearly profited from a permissive immigration policy which enabled most American-born and -educated physicians to practice in 'dignified' conditions.

³⁶ Even if much less ambitious than earlier plans, the initiative was still conceived as a practical exercise, presupposing actual facilities, staff, and patients. Delafield Hospital, publicly-owned but under professional staffing contract with P&S, was identified as the most likely site for the development of "our Community Health Services Program." Certain specific elements of the program were discussed, such as "the desirability to structure a program so as to provide each consumer with ready access to a primary physician." The 'team' approach to health care services, "including the concept of a primary physician in relation to a nurse practitioner, medical assistants and medical technicians," was mentioned as a possible model. ("Notes of Conference," pp. 9-10.)

Planning, Funding, and the Launch

Although at the conference Drs. Bryant, Canfield and Lythcott were identified as three individuals who would be most directly involved in the planning process, this ‘collegial’ vision quickly disintegrated.³⁷ Upon his arrival at Columbia, Dr. Bryant asserted his claim to control the preparation of the proposal, refusing collaboration with Dr. Canfield.³⁸ During the Fall of 1970, it was also decided that the proposed Office would be headed by a director, rather than a new associate dean, and Dr. Bryant was appointed to the post. The work of the Office would be guided by an Executive Committee the chairmanship of which was given to Dr. Lythcott. Dr. Canfield, alas, was informed that there would be no place for him either on the staff or on the Executive Committee. Despite his efforts to stay involved, he was effectively expelled from participation and no one appears to have protested.³⁹

As Dr. Bryant assumed control over the preparation of the proposal, the theme of caution with respect to the scope of Columbia’s initiative evolved to preclude any practical involvement at all, at least not until further research suggested an appropriate methodology for restructuring health care services. Columbia, it was now suggested, should avoid “efforts to establish entirely new and highly innovative systems of health services which run the risk of failure as an experiment in system design or in its replicability or both.” Instead, the initiative’s primary goal would be “to develop the methodology for designing feasible change,” placing it at no less than three degrees of separation from any practical undertaking.⁴⁰

³⁷ *Ibid.*, p. 11.

³⁸ Canfield to Bryant, August 17, 1970.

³⁹ Canfield to Marks, June 11, 1971.

⁴⁰ “A Proposal for Establishing a Capability for Planning, Development, and Evaluation of Health Services,” Columbia University, Faculty of Medicine, from the Office of the Vice President for Medical Affairs and Dean of the Faculty of Medicine, draft, August 1970, p. 3. With minor changes, this draft formed the basis of the version of the proposal completed in November of 1970 and circulated for

The Office of Research and Planning of Community Health Systems (ORPCHS), as a proposed body was now called, was envisioned as a primarily research undertaking. While it was intended that the Office would have “the capability of contributing substantially to the design of new managerial approaches,” the actual management of health care programs would be “the responsibility of the administration of the agency or institution involved, e.g. Presbyterian Hospital, a community-group practice corporation, and so forth.”⁴¹ With no direct involvement in health care provision, ORPCHS would represent “an institutional resource” for those institutions which are or will be responsible for delivery of actual health care services. In spite of this largely consultative role, it was hoped that the initiative’s impact would be “consistent with overall health services systems development and long-range planning.”⁴²

At the same time, the language of Columbia’s proposal was also beginning to align itself with the key terms of conservative assimilation of the health planning movement, including the renewed appreciation of the ‘pluralistic’ nature of American medicine and the concomitant commitment to work within existing institutions.⁴³

comments. The three degrees of separation are: (1) the methodology for (2) designing (3) feasible change.

⁴¹ “A Proposal for Establishing a Capability for Planning, Development, and Evaluation of Health Services,” Columbia University, Faculty of Medicine, undated, probably March 1971, pp. 2-3. The proposal stated that the Medical School’s proposed involvement in community health services would consist primarily in “[s]tudying existing systems and advising responsible agencies” and “[p]articipating with responsible agencies ... in studying and experimenting with health services programs.” Only “[o]ccasionally, perhaps unusually,” would the Office “develop a health services program independently of existing health services agencies, but the reasons for acting independently should be clear, the ultimate disposition of the program understood, and the relevance for city-wide and nation-wide programs established.” (This formulation first appears in a draft, Bryant to Marks, February 11, 1971.) Specific virtue was found in this new vision of Columbia’s involvement, namely, that the Office was “not intended ... to preempt or control other institutional activities relating to community health systems, and it should have no veto over other health services activities.”

⁴² “A Proposal,” March 1971, p. 2.

⁴³ A call to preserve the “pluralistic” nature of American health care and to avoid “simplistic solutions,” – with both terms signifying a thinly veiled opposition to ‘socialistic’ models adopted by Great Britain or Sweden – appeared, for instance, in the 1968 Barr Committee Report on hospital planning. Although set up by the U.S. Department of Health, Education, and Welfare, the Committee was composed of the

Columbia's proposal now insisted that "rapid or substantial changes cannot be expected in a system with the complexity and inertia represented in the interaction of society and its health services." It was proposed that through ORPCHS, the Faculty of Medicine would "seek to establish or relate to carefully selected health care settings or situations that collectively represent the spectrum of health services problems" necessary for research and the teaching of health care planning.

This pluralistic approach to the institution's involvement in health service systems could include, for example, an urban ghetto community, an urban middle-class community, a suburban community, a rural community and when resources are available, a community of a less developed country. In selecting these health settings, the Faculty of Medicine feels strongly that it must begin with the population as it is, the problems as they are, and the system of health services as it exists.⁴⁴

All traces of the earlier, political understanding of the health care crisis were now eliminated, replaced with a narrow, technical-managerial view of the problems. Technical problems implied technical solutions, and academic research, in this increasingly self-referential narrative, was ideally suited to take the lead in finding them. One of Dr. Bryant's drafts, for example, opened with an acknowledgement of a deep crisis gripping the American health care system. "The factors that contribute to the nation's health crisis," he wrote, "are numerous and complex" but for "simplicity in presentation" could be organized under the headings of "inadequate health care" and "inadequate education and training of health personnel." As the subheadings portended, what followed was a laundry list consisting almost entirely of so many "inadequate," "poor," and "lacking" moments of the existing health care arrangements. Numerous features of the "faulty health care systems" were "poorly

major figures in the hospital industry and associate health care fields. (Stevens, "In Sickness and In Wealth," pp. 306-307.)

⁴⁴ "A Proposal," August 1970, pp. 6-7.

designed,” “inefficient,” “ineffective,” “poorly distributed,” and “non-adaptive.” The systems lacked “data systems for planning and evaluation” and an “experimental approach to system improvement,” while the resources were both “poorly distributed” and “poorly used.”⁴⁵ Amidst this barrage of bold assessments, one question was conspicuously absent. What exactly accounted for this state of affairs? How did it come to be like that? Alas, the rest of the document offered no clue.

Even this very ‘technocratic’ discussion of health care crisis, however, was eventually eliminated from the proposal. After reviewing Dr. Bryant’s draft as it stood in November of 1970, Dr. Ginzberg told Dean Marks that he was “quite disturbed by it” and thought “it should be substantially scrapped.” He warned the Dean of “the impatience of most foundation executives that [he knew] with generalized background info and/or broad philosophical propositions.” The whole discussion, he said, was a “windup but ... no pitch” and urged a “much shorter hard hitting document.”⁴⁶ In

⁴⁵ “A Proposal,” August 1970, pp. 3-4. There were, to be sure, a few surprising items on this laundry list of problems. Early in the list of factors contributing to the “faulty health care systems,” there was a “lack of community participation in decision making.” The term ‘decision-making,’ however, clearly did not fit with the thoroughly de-politicized litany of problems and was struck out and replaced with “planning, implementation, and evaluating.” Thus edited, it turned into an almost comical proposition that the fault lay with the community’s failure to engage in the work of rational/technical planning of health care systems. At the end of the list under “inadequate education and training of health personnel,” several factors were suddenly restated in terms of institutional structure, rather than bad management, suggesting that it was the “University structure [that did] not facilitate integrated teaching of different health personnel” and “University structure and custom [that did] not facilitate interdisciplinary, problem-oriented approaches to health services and educational problems.” The final item on the list was most surprising of all, bearing a moral, rather than technocratic, judgement of professional career structures. “Health personnel,” wrote Dr. Bryant, “[was] specialized without regard for pressing needs and areas of outrageous neglect of society.” These departures, however, were few and far between to change the overwhelmingly technocratic tone of the document.

⁴⁶ Ginzberg to Marks, “Personal,” December 14, 1970. Not everyone shared Dr. Ginzberg’s view and a set of comments from another member of the Center’s Executive Committee, the Dean of the School of Social Work, pointed in the nearly opposite direction. Here, the main criticism was that the proposal “refer[ed] to a ‘health crisis’ and ‘health problems,’ but [did] not specify their nature, extent or cause.” It would not be easy “to think out and set down the assumptions about what is wrong, together with such evidence as can be brought to bear,” but the exercise would really help to “tie together other parts of the proposal in a theoretical and practical whole.” [Mitchell I. Ginsberg, Dean, School of Social Work, Columbia University to Marks, April 12, 1971. (The comments were actually made by the Assistant Dean Sam Finestone, whom Dean Ginsberg asked to review the proposal in his stead, for lack of time.)] These recommendations, alas, went unheeded.

subsequent versions of the proposal the ‘broad philosophical propositions’ were trimmed to a short and none-too-explicit paragraph, stating that “the various elements of health services [were] both incomplete and uncoordinated” and that “[s]olutions [were] required at different levels in the larger system – at the level of system elements, and at the level of planning for the overall system.”⁴⁷

While yielding to Dr. Ginzberg’s insistence to scrap the long introduction, Dr. Bryant resisted outlining specific projects the Office would undertake. In a memo discussing preparations for the meeting with foundation representatives, Dr. Bryant insisted that “[w]hile we can be explicit in describing the kinds of problems with which ORPCHS will be concerned, it would run counter to the institutional philosophy on which the development of ORPCHS rests to make a series of programmatic decisions at this time.” In his view, the Office was intended to be “the main institutional mechanism whereby the University and its affiliated institutions become engaged in the health care problems of our society.” Consequently, “to make programmatic decisions at this time would not only preempt decision-making authority that is intended to be vested in the structure of ORPCHS itself, but also would tend to weaken the very process ORPCHS is intended to foster, namely, that process whereby a university examines the health problems of society and determines what the best use of its own resources would be in order to achieve maximum benefit

⁴⁷ “A Proposal,” March 1971, p. 18. More regrettable than the elimination of Dr. Bryant’s mostly technocratic discussion of health care crisis was the loss of several passages where he argued that community participation was crucial because “self-determination was essential to every segment of society and is particularly important to those who are caught in what can be described as modernized, institutionalized poverty.” (“A Proposal,” August 1970, p.10.) Other passages that disappeared were those suggesting that Columbia’s initiative should be oriented to what is basically a “one class patient-care,” where the differences may involve “room size, meals, etc., but they should not involve basic care, not should they make the distinction that now exists in the ambulatory care facilities.” (Unsigned document, “Community Health Services,” August 29, 1970, p. 4.) A quaint proposition that “[o]ne might make, perhaps, a good case the fact that top priority should be placed to improving the level of nutrition in our population” was also never to be seen again. (*Ibid.*)

for society.”⁴⁸ The result of this low-level struggle between Drs. Ginzberg and Bryant was that the proposal ended up containing neither commitments to specific practical goals, nor a coherent view of the problems’ nature.

A series of conflicts and struggles which surrounded the initiative’s planning affected its organizational form as well. Competition for leadership and participation, combined with a rather secretive planning process, dashed the initial hopes for an institution-wide, multi-departmental undertaking. The early visions of the initiative’s organization emphasized two interrelated propositions. First, the initiative was going to be an *office* with an actual mandate to undertake institution-wide or even area-wide planning. Second, to carry out this mandate legitimately and effectively, it would rely on a multi-departmental, or even multi-institutional, structure of agenda-setting and decision-making. In the end, neither of these objectives was realized.

As the erstwhile Office was renamed the Center, its mandate to undertake institution-wide planning was re-imagined as a kind of a leadership by inspiration. The Center’s staff, it was now envisioned, would be drawn from numerous departments, holding joint appointments in the Center and in their departments, and “it would be largely through their academic identification and activity within those departments that change required within the School would evolve.”⁴⁹ The questionable new method of effectuation the initiative’s goals was made even more problematic by the fact that the actual composition of the Center’s staff fell far short of the interdisciplinary vision outlined in the proposal. The final version of the proposal listed, under the Center’s proposed personnel, specialists in 14 academic fields and 5

⁴⁸ “Notes Relating to Further Discussion on the Proposal to Establish an Office of Research and Planning of Community Health Systems in Columbia University Faculty of Medicine,” August 11, 1971.

⁴⁹ “A Proposal,” March 1971, p. 24. The Center’s suggested structure was described as “the administrative framework through which the departments could operate in one or another community health service programs,” as well as “a technically competent resource group.”

clinical disciplines but the actual staff engaged during the Center's first two years was much less interdisciplinary.⁵⁰ Out of the twelve members with academic appointments anywhere within the Columbia University, ten were with the School of Public Health.⁵¹

The composition of the Center's Executive Committee was more representative in terms of academic fields but it, too, was a far cry from the earlier vision, especially in terms of including the interests from outside of the Medical School.⁵² (See Figure 7.3.) Out of the 24 members, 18 held professional or administrative positions at the University, with 15 of them being in the Faculty of Medicine. There were only 6 members from outside of the University: 5 administrators of the affiliated hospitals and one representative of the Health Services Administration.⁵³ While 'community' and 'regional planning groups' were listed as members of the Committee as late as 1974, none of their representatives had in fact

⁵⁰ *Ibid.*, pp. 35-37. The fields listed under the Center's required personnel in the final proposal were: management science, health economics, systems analysis, health planning and evaluation, epidemiology, biostatistics, health care administration, urbanology and the environment, political science, sociomedical sciences, nursing and allied health sciences, educator-curriculum development, information systems, social work, and the clinical departments (pediatrics, medicine, psychiatry, obstetrics and gynecology, dentistry).

⁵¹ "CCHS Annual Report 1973," pp. 24-26. The other two were in the Departments of Pediatrics and Dentistry. Several other fields of expertise were represented among the other staff members but, without the academic or professional appointments at the University or the Medical Center, they could not be supposed to have much influence on the participation of the departments corresponding to their field of knowledge. There were seven individuals with masters degree (or research focus) in city planning, business administration, anthropology, public administration, public nursing, sociology, biostatistics; a post-doctoral fellow in operations research and math theory; two PhD candidates in architecture and in operations research and engineering. One member held academic appointment at the Albert Einstein College of Medicine. One individual with an M.D. was identified only as consultant in pediatrics. The remaining 10 staff members were supporting personnel, community coordinators, research associates and others with a bachelor's degree or less. By the end of 1973, total staff numbered 34.

⁵² *Ibid.*, pp. 6-7. Among the members of the Executive Committee were chairmen of 5 clinical departments (medicine, surgery, obstetrics and gynecology, pediatrics, and psychiatry), 3 professors of public health, and 3 faculty members from outside of the Faculty of Medicine (professors of social work, economics, and biological sciences). The Center's perceived failure to engage clinical departments, despite their representation on the Executive Committee, is discussed below.

⁵³ *Ibid.* One of the 18 held an academic appointment at the Medical School and was a director of a hospital.

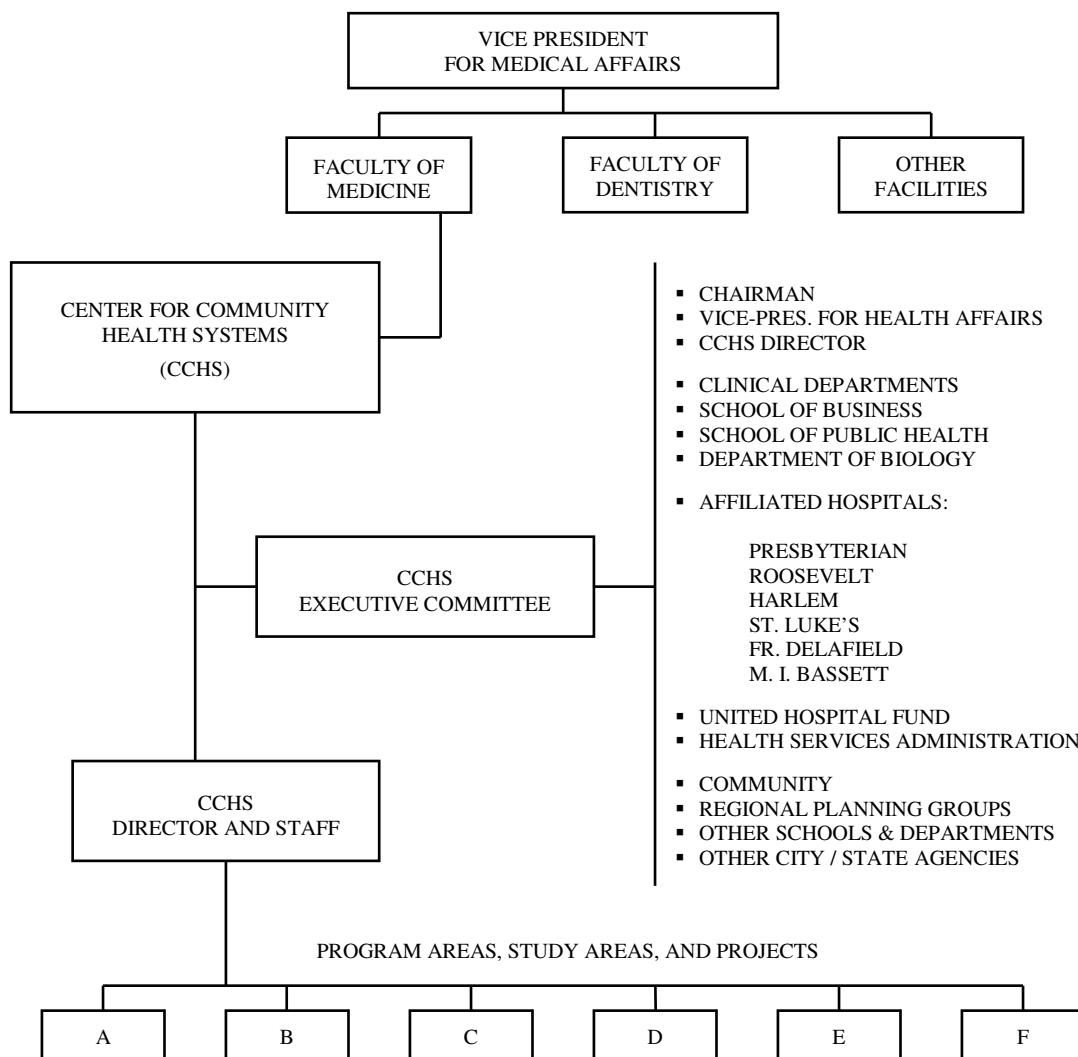


Figure 7.3. Final Organizational Form of Columbia's Community Health Planning Initiative. *Source*: "The Place of CCHS in the Organizational Structure of the University," CCHS Annual Report 1973.

ever been included.⁵⁴ Inclusion of the representatives of the student body, the health commissioners of New York City and New York State, or the representatives of New

⁵⁴ *Ibid.* The Report 'explained' this discrepancy by saying that "[a] long standing discussion with communities is under way to determine the most advantageous modes of community representation on the Executive Committee."

York City County Medical Society, which was initially envisioned, was no longer even discussed.⁵⁵

More problematic than its composition was the fact that, contrary to its name, the Executive Committee ended up having an advisory, not an executive, relationship to the Center. Given its limited power to direct the Center's work, participation of some members on the Committee seemed to be entirely *pro forma*, a matter of organizational courtesy, rather than actual interest. Although the chairmen of five clinical departments were included, the virtual absence of any clinical faculty on the Center's staff did not bode well for actual, practical cooperation. Participation of hospital representatives also did not in fact signify any programmatic commitments.⁵⁶ Compared to initial plans, the Center was likely to have considerably less influence on the University and the hospitals, just as the University and the hospitals would, in turn, have less influence over the Center. Here, then, was a classic compromise yielding yet another insular organizational niche.

As the search for external funding for the Center began, it appeared that Dr. Ginzberg may have been right in regard to some foundation executives. One prospective sponsor, the President of the William Lightfoot Schultz Foundation, Mr. George L. Schultz, responded very much in the way Dr. Ginzberg had predicted, criticizing the proposal as a whole as "a grandiose plan" and its objectives as "too general, too long-range and idealistic."⁵⁷ The lack of specificity did not, however,

⁵⁵ "The Advisory Committee on Planning for Health Affairs would be composed as follows ...," undated, filed March 1971.

⁵⁶ For a fuller discussion of this issue, see the section on the Center's relationship with the hospitals below.

⁵⁷ George L. Schultz, President, The William Lightfoot Schultz Foundation, Clifton, NJ to Marks, May 25, 1971. Asked to comment on the proposal from a 'business' point of view, Mr. Schultz frankly doubted that "any good businessman or firm would support the proposal as outlined." One of his criticisms was that "the explanation of how the function (ORPCHS) can be supported in future years from internal sources [was] hazy and not convincing." He also questioned "whether a 'systems approach' to such an analysis [was] warranted," but if so, recommended finding "an experienced firm

appear to phase the three big foundations – Carnegie, Commonwealth, and Rockefeller – which gave a half a million dollars each to underwrite Columbia’s new initiative. The foundations did, however, communicate their preference that “there be no publicity initiated at this time by the Medical School with regard to the source and amount of funding for the Center.” The Office’s Executive Committee “concurred with the foundations’ positions in this regard and felt that at an appropriate time a suitable mode of strategy would be the issuance of a press release by the foundations announcing the Center’s existence [and] detailed description of its focus and goals.” Once the Center was functional, “announcements could be released periodically describing [its] projects with an added statement concerning the foundations’ backing of the project without necessarily revealing dollar amounts of their support.”⁵⁸ Evidently, the foundations were leery of publicizing such a considerable expenditure without a clear statement of what the investment would ultimately yield.⁵⁹

Receipt of generous initial funding on the basis of an essentially open-ended proposal created a clear opportunity to rethink the Center’s mission: with financial worries quieted for a while, there was an opportunity to raise the ‘hard questions’ again. The first two post-funding meetings of the Executive Committee, however, dashed the hope that the conservative, technocratic drift of Columbia’s initiative might be reversed. At the center of the discussion was a work paper requested from Dr. Bryant by the Committee at the December 16, 1971 meeting. It was decided at the

instead of hiring your own experts.” Finally, he was bothered by “the repeated warning that the design of new systems will involve extensive and complex financial, organizational and administrative problems.” In his experience, “those who begin a project convinced of its complexity find just that and never produce a practical solution. The simplest approach to problems seems to work out best – almost always.”

⁵⁸ Minutes, Executive Committee, CCHS, December 21, 1971.

⁵⁹ When the Commonwealth Foundation did announce its financial support to CCHS, the description of the Center’s mission and expected projects was rather ambitious and contained at least one inaccurate statement asserting that the Center’s Executive Committee included representatives from urban communities. (The Commonwealth Fund Annual Report 1972.)

meeting that CCHS should “relate its efforts largely to the New York City setting, particularly upper Manhattan, [and] focus on relatively few projects in order to have a substantial impact on the health system of that region.”⁶⁰ To help select specific projects for the Center’s immediate involvement, the Committee requested a working paper containing: “(1) an analysis of the existing situation, i.e., the health system, how it functions and what its problems are; (2) a projection of the health care system we think would be desirable and feasible for five to ten years in the future; [and] (3) identification of the areas of action by the CCHS that would be most likely to contribute to the evolution of the health care system in the desired direction.”⁶¹

Facing an assignment too heavy for a one’s week time, Dr. Bryant took the liberty of choosing an alternative approach, developing “a simple inventory of the major problems of the system ... weighted or scored in terms of their importance,” “their vulnerability to improvement over the next five to ten years” and “the extent to which the CCHS, with its special and limited resources, might effect improvement” in these various problem areas.⁶² Abbreviated, Dr. Bryant’s list is shown in Table 7.1, with 1 being the lowest and 5 the highest score.

Understandably, education of health care personnel received the highest score across the board as the area where medical faculty could make the greatest impact. Other high scorers were ‘bad linkages between parts of health care system and bad regionalization,’ ‘payment mechanisms leading to overuse or misuse,’ ‘bad linkages between parts of the system’ in their relation to generating high health care costs, and ‘lack of fiscal and professional accountability.’ The most remarkable result of this

⁶⁰ Working paper submitted by Dr. Bryant for the Second Meeting of the Executive Committee of the Center for Community Health Systems, Faculty of Medicine, Columbia University, December 21, 1971.

⁶¹ *Ibid.* The first word of each of the three points has been changed to start with a lowercase letter for convenience of presentation.

⁶² *Ibid.*

Table 7.1. *Inventory of Health Care Problems Rated in Terms of Importance, Vulnerability to Improvement, and Suitability as Potential Projects for Columbia's Community Health Planning Initiative, 1971*

Health Care Problems	Importance as Problem	Vulnerability to Improvement	Suitability for CCHS
<i>Those problems contributing primarily to lack of effectiveness</i>			
Access to care limited in terms of time of day and location	3	3	4
Limited outreach and follow-up	4	2	4
Bad linkages between parts of the system; bad regionalization	5	4	5
Resources misallocated; too little goes to preventive, primary care	4	3	4
Education of health care personnel	5	5	5
Limited acceptability of care	3	3	4
Consumer education	4	2	3
Quality review	2	2	3
Socio-economic-environmental factors	1	1	1
<i>Those problems contributing primarily to high cost</i>			
Payment mechanisms leading to overuse or misuse	5	3	5
Linkages between parts of the system	4	4	4
Consumer education	4	2	3
Lack of fiscal and professional accountability	3	3	5

Source: Working paper submitted by Dr. Bryant for the Second Meeting of the Executive Committee of the Center for Community Health Systems, Faculty of Medicine, Columbia University, December 21, 1971.

tabulation, however, was an uninterrupted row of straight 1's assigned to 'socio-economic-environmental factors.' A footnote explained that "[w]hile these problems

are of great importance to society and influence health in strong ways, they are largely outside of the health system as such.”⁶³

Having identified ‘systems planning and regionalization’ as the most promising problem to work on, Dr. Bryant’s paper suggested “that CCHS initiate as one of its major projects the study and continuous monitoring of the health care system of upper Manhattan.” Sensing the impatience of the Executive Committee to define practical areas of involvement, he suggested that, while waiting for the result of this major undertaking, the Center should select several areas of involvement “on the basis of general knowledge of health care problems,” citing ambulatory care as a likely point of departure.⁶⁴ A question, which arose during the previous meeting, was whether it was “possible for the CCHS to contribute to the evolution of a more effective and financially viable system of health services in upper Manhattan that involves the coordination and collaboration of health services provided by various institutions, practitioners and community groups.” In other words, could the Center successfully promote ‘systems planning and regionalization’? Dr. Bryant’s answer was elusive. The goal behind the idea of regionalization could be expressed as “the allocation of services in such a way as to allow for the provision of care to the right person, at the right time, in the right place, and for the right reason.” At the level of institutions, regionalization implied an “attempt to balance the need for decentralization of resources with the centralization required for their efficient usage.” Given “the highly pluralistic character of the current health system,” Dr. Bryant believed that “an intimate and continuously expanding understanding of that system

⁶³ *Ibid.*

⁶⁴ *Ibid.*

will be required to make wise decisions on how the CCHS can contribute most effectively to its improvement.”⁶⁵

A remarkable thing about this answer was that, not too long before, Dr. Bryant took a very different approach to analyzing whether regionalization efforts could succeed. In a January 1971 memorandum to Dean Marks, concerning the two pieces of federal legislation known as the Regional Medical Planning (RMP) and the Community Health Planning (CHP) initiatives, Dr. Bryant pointed out that both programs “lack[ed] the power of implementing decisions they might make” and, therefore, “[would] probably fail.” Neither was likely to reach its objective because “the decision-making power that actually determined the patterns and levels of health care [had] been untouched by these steps.”⁶⁶ In regard to allocation of health care resources, hospitals remained the most powerful actors, while the utilization of hospital and ambulatory services continued to depend on the decisions of the practicing physicians.

The political ‘toothlessness’ of these bills was related to the manner of their creation, bearing the heavy hand of the organized medical profession. “The RMPs have ended up as funding agencies with specific legislative injunction (of AMA origin) against changing present patterns of practice,” while “[t]he CHP programs (with similar injunctions) have relied on existing political machinery, but have not had the power of implementation.” With their powers largely untouched by the regionalization bills, physicians and the hospitals were unlikely to undertake health care planning voluntarily. Under any regional plan, individual hospitals “stand to gain or lose according to how a plan of regionalization adds to or detracts from their programs and resources” and would therefore oppose all efforts which hurt them.

⁶⁵ *Ibid.*

⁶⁶ Bryant to Marks, January 25, 1971.

Physicians were also unlikely to change their decisions controlling utilization of hospital and ambulatory services because “their system of practice and payment [was] not conducive to regionalization.”⁶⁷

Did not a similar conclusion – or at least a similar manner of analysis – equally applicable to Columbia’s health planning initiative? Was it likely, for instance, that the CCHS would have significant powers to implement the changes it deemed necessary? How influential – or even independent – was the Center vis-à-vis hospitals and physicians, in structural terms? Was the CCHS going to be any more successful in promoting ‘regionalization’ than the ‘doomed’ CHP or MPR bodies and, if not, could both be strengthened by an alliance? Although general questions about the Center’s likely influence were still raised from time to time by some members of the Executive Committee, the inclination and capacity to answer them honestly appears to have been lost quite some time ago. Elimination of any and all political analysis from the conceptualization of Columbia’s initiative and recasting the problem in strictly technocratic terms appeared quite final.

By January of 1972, the evolution of Columbia’s community health planning initiative from tentative discussions to an official undertaking was complete. Less than two years after the planning began, the initiative stood substantially different from the initial visions. The goal of reforming the organization and delivery of health care services at the Center gave way to an understanding that “rapid or substantial changes cannot be expected.” The idea of creating an actually functioning program of innovative services was put off until “the methodology for designing feasible change” was at hand. The demand to redistribute professional rewards from private to

⁶⁷ *Ibid.* Dr. Bryant also pointed out that “[l]acking actual power, [CHPs] have often sought it through community boards.” How Columbia’s initiative would relate to community boards in its turn and, by extension, to the larger political process involved in these legislative bills, is a question examined in the next section of the chapter.

community medicine was rescinded in favor of preserving the medical faculty's "way of life," while the calls for a one-class system of health care were displaced by a renewed appreciation of America's "pluralistic" health care system and rejection of any "simplistic approaches." In the end, all openly political and moral understandings of America's health care system fell silent before the steady drone of politically 'neutral' technocratic discourse.

While, in the beginning of the journey, academic 'progressives' appeared to have a common cause, the initiative's development was marred early on by interpersonal and inter-departmental conflicts which all but destroyed the possibility of a genuinely co-operative effort. That the mechanisms to prevent the conflict – or to bring it out in the open for an institution-wide discussion and mediation – did not exist, or were not engaged, bespeaks the weakness of the presumed structures of academic 'collegiality.' Closed-circle decision making throughout the entire conceptualization of the community health initiative, was implicitly justified by the existence of powerful forces of opposition within the Medical Center. How much was gained by the secrecy is unclear but, certainly, much was lost. Just when the political climate finally enabled the Center's 'progressives' to press their agenda, they chose instead to fight among themselves. Using the old means of decision-making and power-sharing to generate the new ends of community health care was a crucial mistake of the planning process, indicative of the failure to understand the complicity of the basic organizational structures of American academic medicine in the very processes that precipitated the community health care crisis.

The initiative's irreversible slide into the technocratic conservatism signified more than simply a triumph of one interest over others. It pointed to a systematic effect of the institutional power on professional work, prevailing even in the more militant climate of the early 1970s. Both career-motivated power struggles and the

general imbalance of power in a hierarchically structured organization inclined the early contenders to purge more radical moments of their views, especially those pertaining to internal politics of academic medicine. Suppression of the political understanding, in turn, allowed the planners to skirt many crucial issues pertaining to the nature of the health care crisis. Although the technocratic turn was strongly motivated by disincentives to internal institutional critique and reform, it had important consequences for relations with external forces. The early understanding of the community health planning initiative as a matter of internal reform suggested that academic progressives had a shared cause with those outside of academic medicine who demanded or worked for reform, including communities, students, and progressive public figures. When internal conflict of interest became taboo in the thinking about the community health planning initiatives, the interest 'lines' were restored to their traditional shape, binding participants to their immediate personal career interests. This assertion of institutional power, which forced an increasingly inward view of the community health initiative, also discounted and ignored external forces and actors. The refusal to know, therefore, was dual, encompassing both self (i.e. one's institutional, professional and social location) and others (external actors). In a nearly classic Hegelian manner, the planners' failure to know themselves had as its corollary an instrumental, exploitative relationship to external others, including those with whom academic liberals might have been expected to form a unified front for social change.

Community Health Care and the Community

'Community' was one of the central terms of the health care reform movement of the late 1960s and early 1970s and usually connoted a dual concern of improving community health care services and establishing mechanisms for community participation. Judging from the views expressed by the initiators of Columbia's

initiative, there existed a foundation for a broad consensus on the issue of community. All the key figures, including Drs. Bryant, Canfield, Ginzberg and Lythcott, agreed that, like other urban medical centers, Columbia University and its affiliated hospitals had been legitimately criticized for their indifference to the community in which they exist. All of the planners felt that the University and the Medical Center could no longer maintain their traditionally aloof stance and had to devote more attention and resources to serving the surrounding community. Most importantly, everyone seemed to agree that the 'community' in question consisted primarily of those lower socio-economic groups that were so inadequately served by the urban medical centers and the health care system as a whole.⁶⁸

On the question of the community's participation in the health planning process, however, there were some differences among the key players. For Dr. Canfield and his colleagues, establishing community participation was not a central issue, not because its input was unimportant, but because responsible physicians and administrators knew full well what needs to be done to improve community services.⁶⁹ For Dr. Bryant, in contrast, community participation was a crucial issue, rooted in an understanding that "[s]elf-determination is essential to every segment of society and is particularly important to those who are caught in what can be described as modernized, institutionalized poverty."⁷⁰ For Dr. Lythcott, the issue of inviting community participation was also a central element of the health planning initiative,

⁶⁸ "Community Medicine: A Study of Several Medical School Programs in the USA;" Canfield, "Confidential Private Copy."

⁶⁹ For Dr. Canfield and his colleagues, the main issue was raising professional prestige of primary care and devoting more institutional resources to ambulatory medicine, not inviting community, yet again, to express its grievances. (Canfield to Aranow, August 13, 1970; Alan Robinson to Canfield, August 10, 1970.)

⁷⁰ "A Proposal," August 1970, p. 10. The view that the community in question was "caught in ... modernized, institutionalized poverty" was weakened, however, by the simultaneous assertion that health outcomes were primarily "dependent on personal decisions made in the privacy of families and communities."

even if a difficult task at the same time. In his view, community participation “inevitably entail[ed] a significant degree of confusion and conflict” because there was “no easy way for two groups – the community and the medical school – with conflicting goals and priorities to resolve their differences.”⁷¹

The medical school’s recent experiences with inviting community participation seemed to confirm Dr. Lythcott’s assessment. Early efforts by the Office of Urban and Community Affairs to generate community support for the feasibility study of an HMO program, for example, uncovered an impressive intensity of “hostile feelings and suspicion against the motives and alleged past practices of Columbia University.” As one of Dr. Lythcott’s colleagues reported, the majority of community organizations “have greeted us with suspicion, distrust, or outright hostility” and securing their collaboration has been very hard.

Many [organizations] have agreed to work with us only on condition that we form a committee representing all interests involved – provider and consumer, but dominated by consumers – which will collectively carry out all further investigations and planning for the project. Agreement with this demand has been the only means by which even minimal community acceptance could be achieved. Several groups have re-requested, additionally, that all agreements made be ratified by the University in writting (sic); others have refused or balked at participating entirely.⁷²

In the two areas “around which the future of the Center for Community Health Systems and other activities of ours will depend” – the Morningside-Riverside and the Washington Heights – the situation with community relations was likely to be further

⁷¹ The reasons for the unavoidable conflict between the two sides was explained as follows: “Professionals feel threatened by strong community advisory boards, while community feels itself exploited and manipulated if it is not given significant control over programs which effect its health. The community is naturally most concerned with the quality of service it receives which the medical school’s priority concern is the quality of teaching it can provide. It has often been difficult, in addition, for institutions to decide who really speaks for the community, particularly in a large urban area with a number of competing groups and ideologies.” (“Community Medicine: A Study of Several Medical School Programs in the USA,” p. 65.)

⁷² Bernard Challenor, M.D. to Lythcott, “Confidential,” September 20, 1971.

complicated by the growing ethnic polarization between the African-American and Puerto-Rican communities. As difficult as the situation was in Harlem, noted Dr. Lythcott, it was “made easier by the fact that [his] office is substantially Black, and ‘Brothers’ just naturally do business better with ‘Brothers’; not to take anything away from the hard work of many people who have brought the relationship to where it is.”⁷³ The only way out of this situation was to engage in “open and active cooperation, participation and communication” between the University and the community groups and to position the community health planning initiative as “a group effort acting collaboratively with, but not attempting to dominate or manipulate in any manner, such community groups.”⁷⁴

These understandings notwithstanding, around the time of its launch, Columbia’s community health planning initiative appeared to be moving away, not toward, greater cooperation with the community. Dr. Bryant’s lofty language about ‘self-determination,’ as well as such unambiguous terms as ‘community participation in *decision-making*,’ were deleted from the proposal. In a break with the initial discussions and plans, no community representatives were included in the Center’s structure in any capacity. A proposal to include community service as a factor in

⁷³ Lythcott to Marks, “Confidential,” October 7, 1971, a cover letter sent with Dr. Challenor’s communication.

⁷⁴ Challenor to Lythcott, September 20, 1971. Although vague, this message was at least earnest and well-meaning, whereas some other recommendations smacked precisely of the manipulation Dr. Challenor warned against. In Dr. Lythcott’s view, for instance, the matter seemed to be one of consistent institutional presentation and, specifically, of “maintaining excellent lines of communication in the Medical Center internally, but especially between the Medical School and the Campus.” (Lythcott to Marks, October 7, 1971.) A critical factor was “a sense on the part of the community that the medical school ... is not only firmly committed to their interests but *believes that the community possesses some knowledge and skills which are essential to making decisions affecting their health care.*” (“Community Medicine,” emphasis added.) The failure to specify what these “knowledge and skills” might be hinted at a certain disingenuousness at the heart of this well-meaning discourse, while the emphasis on the school’s ‘attitude’ and community’s ‘beliefs’ presented the issue as one of image-management, rather than of principled position.

faculty promotion received only tepid support from the CCHS leaders.⁷⁵ Not surprisingly, the Center's relationship with community groups began on a note of confrontation.

In March of 1972, CCHS was contacted by a group calling itself the 'Organizing Committee for Comprehensive Health Planning (CHP) – Manhattan North.'⁷⁶ The group informed Dr. Bryant that, about a month before, they learned that, for over a year, CCHS had been working on an Emergency Services (ES) project and expressed dissatisfaction with the fact that, although the Center had been meeting with community groups, the existence of the ES project had been neither discussed, nor publicly announced.⁷⁷ While "any improvement in emergency room care [would] be welcome," the group said, the project had implications reaching "far beyond the hospital ER" and the community had a legitimate interest to be informed about its scope and goals.

Manhattan North held the view that 'neighborhood health services,' rather than hospital outpatient clinics, should be given the highest priority in the efforts to

⁷⁵ Morton D. Schweitzer, Ph.D., Professor of Epidemiology, Columbia University, School of Public and Administrative Medicine, to William J. McGill, President, Columbia University, December 27, 1971; McGill to W. T. deBary, Vice President, Columbia University, February 22, 1972; DeBary to McGill, April 16, 1972; Lythcott to Marks, April 27, 1972.

⁷⁶ In a later report, the Center's community coordinator, Ms. Garvin, wrote that Manhattan North was "the most active group with which we have had continuous relations, the one nearest, geographically, to Presbyterian Hospital, the Medical School and the Center." "I am not familiar with its origins," she wrote, "but it seeks recognition from the City as the CHP agency in District E. ... It is the most ambitious group politically with which we deal and the most vocal in respect of our projects. The main organizer, Dr. Joel Rothschild, formerly on the staff of Columbia University as a physicist, is a competent and knowledgeable person who plays a major role, ideologically and organizationally. 'Manhattan North' has succeeded in maintaining a sizeable membership core of persons from the main organizations in this area for over a year, meeting every week and publishing a newsletter with a distribution of approximately 700. ... Although 'Manhattan North' has not yet been certified by the City CHPA, it has achieved de facto recognition as a viable community group by the Center. As I understand the situation, the main bone of contention is the City's guideline requiring its approval of local leadership as opposed to the autonomy of the community in making selection. ("Report on Community Relations," presented by Vicki Garvin, Area Leader for Community Interaction, at Staff Meeting of CCHS, May 24, 1973.)

⁷⁷ Organizing Committee for Comprehensive Health Planning (CHP) – Manhattan North, draft of a community letter prepared by Baldwin, Pynoos, Straus, Rothschild, Saxl, June 12, 1972.

improve community health care.⁷⁸ They suspected, however, that the Center's project would focus exclusively on the hospitals' outpatient departments and might therefore be detrimental to the development of neighborhood health centers. Outraged that the community was not consulted in this important matter, Manhattan North Organizing Committee issued an open letter to the CCHS, requesting clarification of the ES project and the Center's policy in regard to community participation.

Two meetings were held between the leaders of Manhattan North and the CCHS, at which Dr. Bryant agreed to issue a statement addressing the questions posed in the open letter. The main thrust of Dr. Bryant's statement was that, in his view, the goals of CCHS and Manhattan North were "complementary, not competitive."⁷⁹ Improvement of primary health care services in upper Manhattan was a common concern of both the CHP and the CCHS. Determining the best way to approach the problem, however, was "a complex issue."

All of us agree that primary care is not always well handled, and there are many ideas about the best approaches to be taken. The CHP Committee is looking toward family-oriented community services, possibly in neighborhood

⁷⁸ *Ibid.* The letter stated this position as follows. "The hospital ER does two different things: emergency care and also substitutes for the fast-disappearing family doctor. The community has long complained that this second job is done badly, and many health experts don't believe that even the best hospital out-patient clinic can ever provide a family with the kind of care they want. ... Since the hospital clinic may never be the best way to give family health care, many people are looking for ways to bring the traditional family doctor back to the neighborhood. (NHCCs, HMOs, etc.)" The letter stated that there is likely to be a real conflict of interests between hospitals and neighborhood health centers. As the matters stood at present, they noted, "neighborhood health services are in competition with the hospitals, even though they must have hospital cooperation." The efforts to establish neighborhood health centers already faced multiple obstacles. Obtaining the means to finance them, noted the group, would be a struggle, "even if the community doesn't (sic) have to compete with hospital clinics for the same dollar." The group's concern regarding Columbia's efforts was that "[i]f this [Columbia's] ER project emphasizes non-emergency clinic services in the hospitals in a way which interferes with community efforts to bring the doctor back to the neighborhoods, it would be just another example of one program destroying another. The purpose of CHP is to prevent this kind of waste of community resources."

⁷⁹ "Statement on Emergency Services Study by John Bryant, M.D.," June 1, 1972.

family care centers. The CCHS is studying one specific part of the primary health system, the emergency services.⁸⁰

While saying that it was “reasonable that a substantial amount of care can be provided outside the hospital setting, possibly in family oriented community health facilities,” Dr. Bryant was elusive on whether the ES study actually included non-hospital primary care settings in its purview. Although it study was apparently “concerned with all facets of urgent and non-urgent ambulatory care all the people in upper Manhattan, whether this care is given inside or outside hospitals,” the statement identified five hospitals to be studied, but no non-hospital settings.⁸¹

Not surprisingly, Manhattan North did not find Dr. Bryant’s statement to be very forthcoming on the main issue of interest to the group, the study’s relationship to the neighborhood health centers. “Dr. Bryant’s June 2 statement,” they commented, “is the first mention of studying ‘the availability of community resources outside the hospitals’ but *increasing* this availability is not given as a goal, and it is not explained how this project will aid this goal.” On the basis of this statement, the group could not recommend a specific position that the community might want to take in regard to the ES project or the CCHS as a whole, warning that

[c]ommunity benefit depends upon community participation in setting goals and in guiding any project toward community goals. Otherwise community involvement will simply be used as false testimony that the community participated.⁸²

Indeed, one of the novel and sensitive elements of the community health care planning was that the demonstration of community support was required of all projects applying

⁸⁰ *Ibid.*

⁸¹ *Ibid.*

⁸² “History of the Emergency Services project.”

for federal funding.⁸³ While the community groups continued to disagree on how they should relate to Columbia's new initiative, CCHS was making no suggestions of its own regarding the establishment of mechanisms for community participation. If community groups continued to engage the Center, pressing it to "[s]pecify the neighborhood services now being studied and [to] show how the project can strengthen these services," the Center chose to leave these requests unanswered.⁸⁴

It is this pattern of unresponsiveness that may have finally led the community organizations to try a more radical strategy. In October of 1972, Manhattan North and three other community organizations decided to convene a public meeting to establish a community policy toward the CCHS and to propose that the Center be placed under public governance.⁸⁵ In a public statement issued before the meeting, the groups argued that "[the Center's] mission to improve community health care delivery in Harlem, Northern Manhattan and the Upper West Side requires that these communities be given a decisive voice in defining goals, setting priorities, selecting projects and personnel and evaluating performance." The essence of their position was laid out in the following passage:

The CCHS seems to be an Agency for improving community health systems through research financed with public money. Both the spending of public money and its use to change health care should be guided by consideration of the public interest. The public interest should be the first consideration in picking projects and hiring staff for them, in setting goals and

⁸³ An internal document confirmed this understanding on the part of the CCHS leaders: "... community support is necessary for funding purposes." ("Relationships between Communities and the Center," Drs. Lythcott, Bryant and Novick, Agenda, Meeting of the Executive Committee, December 19, 1972.)

⁸⁴ In particular, they asked the Center to draft "an individual research plan for each of the major neighborhood services – 145th St NFCC, Family Planning and Guidance Center, Mental Health Center, H.I.P. Groups – as well as for areas now without such services." ("Columbia Answers Community Questions on Emergency Services Project," Organizing Committee for Comprehensive Health Planning (CHP) – Manhattan North, Weekly Health Report, No. 13, June 27, 1972.)

⁸⁵ Organizing Committee for Comprehensive Health Planning – Manhattan North, "Report of joint meeting on Columbia's Center for Community Health Systems," November 8, 1972.

planning research projects, in carrying out its recommendations and evaluating results.

Who is best able to judge the public interest? Professional health workers are an important part of the decision-making team. They draft alternative proposals and advise about likely consequences of a choice, but they are often not in a position to judge the public interest. It is easy for them to confuse personal career interests, and the interests of their institution, with the public interest. Many health professionals never even consider the public interest.

The way in which the CCHS has handled its first project, the Emergency Services study, seems to illustrate the dangers when decisions affecting the public interest are made without adequate safeguard of the public interest. The public interest should be determined by people who are deeply concerned, but who have as little conflict of interest as possible, people who listen to their neighbors and who see themselves as the trustees of the public interest. This is why Federal Law defines the CHP “Partnership for Health” as a joint decision-making body including concerned health professionals, but with a consumer majority.⁸⁶

The community organizations’ experience with the Center’s ES project offered strong evidence for the need to establish community control over its work. Not only did CCHS initiate the project without consulting or informing the community but, even when pressed, it failed to openly discuss the parameters and aims of the study. The Center’s secretive process, combined with an exclusive focus on well-established institutions, were hardly in the public interest.⁸⁷

The call to place CCHS under public governance propelled relations between the Center and the community groups to a new level of intensity. Columbia’s evasive tactics – in everything, from defining its projects to establishing the mechanisms for community participation – were the main bone of contention during several face-to-

⁸⁶ *Ibid.*

⁸⁷ *Ibid.* As Manhattan North and other community groups would find out later on, CCHS’s initial funding, as well as funding for all current projects, was actually coming from private foundations and not from public sources. Community organizations’ position extended, in principle, to private funding as well, to insist that community review be required for receipt of private, as well as public grants. Regardless of the source of financing, the Center’s activity was essentially public and political in nature. In this perspective, the right of the private agencies to intervene as they pleased in the essentially public and political domains was an idea whose time has passed. (Gino Crocetti, Organizing Committee for Comprehensive Health Planning – Manhattan North to Mrs. Annie Lee Schuster, Executive Assistant, Grants Management, Robert Wood Johnson Foundation, October 31, 1973.)

face meetings that followed. Responding to criticism that the CCHS did not invite sufficient involvement of the community in their work, a member of the staff said that the Center “hoped to have the active participation of the community in the future directions of the ES Study, and hoped through meetings such as this to gain an understanding of the community’s priorities.” To this platitude, community members retorted that “the Center could learn about community priorities by attending community meetings, such as the regular CHP meetings.” As another community representative summed it up, their deeper fear was that “Columbia seems to be looking for the community to play an advisory role, leaving the institution in a position to do what it wants with the advice.” Unfortunately, he added,

[t]he community is tired of playing advisory roles. Talk to us as true partners. If you are expecting only advice, that’s one thing; true community support is another.⁸⁸

“Our concern,” said another representative, “is based on past relationships with Columbia; we want to make sure we aren’t being used.”⁸⁹

Frustrated with the academics’ carefully calculated statements, community leaders confronted the academics with a few basic facts which the Center’s leaders studiously hid from themselves nearly from the start. “The unstated goals of the Center are also important” to elucidate, insisted one community group representative:

The Emergency Care Study is being used as a club with which the liberals at the Medical Center hope to get the hospitals to change. Why should the community help them fight their battles? The Center is trying to show the community who has power at the Medical Center. It functions as a middle-

⁸⁸ *Ibid.*

⁸⁹ Organizing Committee for CHP – Manhattan North, “Meeting with Center for Community Health Systems – Tuesday, December 5, 1972.”

class employment agency. It doesn't ask political questions. There is no public accountability.⁹⁰

While victory by 'the liberals' at the Medical Center might be something to desire, commented another community leader, bringing decent primary care services to the neighborhoods was a cause "more important to this community than administrative changes in the hospitals." The Center could be much more useful to the community if it focused its ES study on the neighborhood family care centers (NFCCs), insisted the community leaders. "If the NFCC comes to the Center for assistance, the Center would be glad to give it to them," said the Center's representative, in a thinly veiled reminder of who the experts were and who, therefore, had to come to whom. The response from the other side was that "the community must be in control; they need hired help, not someone to tell them what to do."⁹¹

The conflict was not, however, simply one of power and control, but also of substantive views on health care reform. If the Center's leaders had concluded that no radical changes could be expected in American health care and decided to stay close to the realities of the current system, the community leaders thought that new institutions and approaches should be developed. Whereas CCHS ostensibly decided to work within and with the existing health care institutions, the community groups maintained that "American emergency services are generally out-dated, and according to the Federal Government many die needlessly." Citing as one interesting an example "[s]everal foreign countries are now saving lives with special mobile emergency units which bring the doctor to the patient, start treatment promptly, and then take the patient to the right hospital."⁹² The community groups insisted that the basic decision

⁹⁰ *Ibid.*

⁹¹ *Ibid.*

⁹² Organizing Committee for Comprehensive Health Planning – Manhattan North, "Report of joint meeting on Columbia's Center for Community Health Systems," November 8, 1972.

for this ES project was whether looking at these new ways or limiting the project to improving emergency services in Columbia-affiliated hospitals.

The unsettled state of the Center's community relations was increasingly becoming a matter of contention among the members of the Executive Committee, both as an issue in itself and as a stand-in for other conflicts. The committee's 'radicals' insisted that improving the Center's relationships with the community was not a matter of hiring special 'community coordinators' or issuing public relations literature, but of actually improving the health care service the Medical Center delivers to the community. "They [the community] feel the Medical Center takes care of Kings, Queens and celebrities from all over the world," said one member, "[w]hy can't they receive better service."⁹³ 'Moderates' countered by asking "[w]hat [was] meant concretely by the Center improving the services 'to this community' that is made up of a large number of sub-interests?"⁹⁴ Representatives of the clinical departments, for their part, were upset that the issues of community relations, consumer attitudes, and patient perceptions, etc., were taking the focus off the practical work to reform the Center's ambulatory and emergency services.⁹⁵

Despite the intensified external criticism and internal dissent, the Center's leadership avoided addressing the fundamental issues, preferring a 'management'-type approach. Although the Center's relations with the community groups were

⁹³ Minutes of the Center for Community Health Systems, Executive Committee Meeting, February 20, 1973. The quoted utterances attributed to Mr. Joe Terenzio.

⁹⁴ *Ibid.* The quoted utterance attributed to Dr. Ginzberg.

⁹⁵ *Ibid.* "We had agreed to look at the medical problems of emergency care," complained the chairman of Department of Surgery, "where we can define where we know the difference between what should be done and what we are doing but ... now we have moved off into worrying about waiting perceptions, etc." While this position was clearly indicative of the well-entrenched 'differences' between clinical and non-clinical departments, it was also cognate with the position of Dr. Canfield and his group, 'expelled' from the Center's direction during the planning stages. Thus, it hinted at the deeper issues surrounding the initiative.

deteriorating, giving up on them was not an option.⁹⁶ As one internal communication put it, these relations were important because “of the substantial contributions communities can and should make in our understanding of problems and our developing effective approaches to those problems, and *because community support is necessary for funding purposes.*”⁹⁷ In light of these understandings, the Executive Committee decided to hire two individuals to fill the positions of ‘community liaisons.’⁹⁸

Although some progress was noted during the following months, a comprehensive report issued in May of 1973 by the chief ‘community liaison,’ Ms. Vicki Garvin, showed little improvement in the Center’s relations with the community.⁹⁹ According to the report, a major problem in the relationship was the primarily research-oriented nature of Columbia’s community health care initiative.¹⁰⁰

⁹⁶ “Relationships between Communities and the Center,” Drs. Lythcott, Bryant and Novick, Agenda, Meeting of the Executive Committee, December 19, 1972. Cited as the reasons for this state of affairs were: (1) “the history of poor relationships between communities and the University and Medical Center” (2) “the differences between community groups and CCHS in goals and approaches to problems and ... difficulties in finding mutually acceptable mechanisms for relating to one another.” The nature of these ‘differences’ was again left underspecified.

⁹⁷ *Ibid.*, emphasis added.

⁹⁸ CCHS, “Review of Current Issues,” Discussion with Dr. Marks, CCHS, October 12, 1972.

⁹⁹ “Report on Community Relations,” presented by Vicki Garvin, Area Leader for Community Interaction, at Staff Meeting of CCHS, May 24, 1973. Report of progress included greater success in soliciting community groups’ input on Center’s grant applications, the filing of joint grant applications, and modifications in the scope and substance of two projects in accordance with community’s input. (Minutes of the Center for Community Health Systems, Executive Committee Meeting, February 20, 1973.)

¹⁰⁰ Ms. Garvin’s report noted at the outset that the Center’s relations with the community were necessarily imbedded in the larger context of the community’s relations with its parent institutions – the Columbia University and the Columbia-Presbyterian Medical Center – with which, as its author diplomatically put it, “the community has had a series of significant differences.” Specifically, Ms. Garvin reported that “[a] segment [of the community], especially in Washington Heights, is concerned about the failure of the hospital to sign an agreement with the certified union, the continued expansion of facilities for Columbia on valuable property at the expense of much needed housing in this area, the refusal to grant a five-year lease to the Washington Heights Day Care Center currently operating on a site owned by Columbia for which no other plans have been announced and the University’s resistance to setting up a committee to supervise an anticipated agreement to hire minority workers for construction of the new library.” Partly as a result of these experiences, she wrote, “[the Center’s] attempt to establish a precedent of community involvement in our research and development projects, while welcomed, is still viewed with some skepticism in some circles.” The community organizations

“[A]lthough there is some recognition of the validity of study projects,” wrote Ms. Garvin, “it is apparent, in terms of priority, that because of the inner city’s urgent need for better health care and delivery, there is relatively little interest in supporting the activities of an institution geared mainly to research, especially if the results are long-term in realization.” As a members of the research center’s staff, she added diplomatically, “[w]e here more fully appreciate the necessity and importance of research planning because we, too, wish to effectuate needed changes.” The community, however, is afraid that the Center will inevitably “follow a traditional pattern of research organizations which call upon consumers to participate for the ‘nth’ time to document a need for reform” without any assurance that the findings will “have some real possibility of being implemented.” The community believed that the current crisis in urban health care required not more research into organization of health services but rather increased “budget appropriations by Federal and local governments for delivery of services.” In this view, noted Ms. Garvin, the solution “lies in political activity by the masses of people directly affected, a cause which logically deserves whatever assistance we can add.”¹⁰¹

Another serious issue standing in the way of better relations between the Center and the community was the latter’s suspicion of the true institutional and class interests motivating the Center’s creation and activity. “[I]t has been brought to my attention,” wrote Ms. Garvin, “that a number of people question our sincerity and commitment to the goal of genuine community participation in the belief that we are making superficial gestures in order to comply with fund granting requirements.”

are “well aware that [the Center is] an arm of Columbia University with an interlocking directorate” and the Center cannot be easily dissociated from the responsibility for these other institutional positions. Ms. Garvin’s message, however, appears to have been about broadening the Center’s view of their role, rather than with placing the blame for its troubles elsewhere.

¹⁰¹ *Ibid.*

As they see it, the burden of proof to the contrary is upon us in light of their previous experiences. Occasionally some of us are even branded as a professional elite, collecting high salaries, raising false hopes and using them as a facade for academic explorations to enhance our own image.¹⁰²

The Center's most recent efforts to improve community relations presented a mixed picture. CCHS "took the first concrete step forward at the tail end of our preparation of the Emergency and Primary Health Care Proposal when we invited *last minute input* from the three main community organizations." Since this was done last minute, however, only Manhattan North CHP accepted the invitation to comment. The Center also made the right choice to invite broad community input of its Child Health Care Proposal. Unfortunately, community organizations showed little interest in the Center's suggestion that they organize community meetings in their areas to get input from parents, teachers, and other interested people and the Center had to take upon itself the organization of the meetings. Despite considerable publicity, only 30 persons attended, mainly parents, seven or eight of whom expressed interest in the follow-up information. The deeper issue revealed in all these instances was that, despite greater efforts to involve the community, "the question of our formal structural relationship with the community – their regularized participation in the Center's activities" – remained unresolved. Garvin stated that despite the Center's "willingness to have some [community] representation on our Executive Committee. . . the mechanism has not yet been set up."¹⁰³

In light of these problems, it was hardly surprising that some organizations simply refused to deal with the Center altogether. The West Side Health Action

¹⁰² *Ibid.* Clarifying the extent of critical views of the Center, Ms. Garvin noted that, generally speaking, "apathy towards the Center may be the dominant attitude" among the ordinary people. Critical attitudes of the sort she described were held among the leaders and active members of community organizations. This was not, however, to suggest that the state of community relations was better than it seemed. Rather, the 'community' of relevance to the Center were precisely these more vocal and critical segments.

¹⁰³ *Ibid.*

Coalition, for example, has given “no response whatsoever to our attempts to involve the Coalition directly in formal comments on our two major projects.” In Ms. Garvin’s assessment, “until a formal structure is set up for community participation in the Center’s activities which is acceptable to the Coalition, this group prefers not to be associated in any respect.”¹⁰⁴ The Center’s relations with the Harlem Health Alliance were “at a lower pitch but not without strain, probably because in several instances Columbia University has played a positive, supportive role.”¹⁰⁵ Relations with the strongest, “most vocal” and “most politically ambitious” of all area community groups – Manhattan CHP – were difficult as well. Despite a great deal of respect for the “dedication, hard work and leadership” of Dr. Rothschild, both among members and other community groups, CCHS’ leadership and staff typically found the group’s ideas “provocative” and its tactics in regard to the Center “intemperate and high-handed.”¹⁰⁶

The report’s overall conclusion was that “although we are inching along, the Center is by [no] means over the hump as of now in establishing satisfactory working relations with our total community.” The situation could and should be improved, Ms. Garvin believed, “provided we patiently persevere in our sincere commitment to react positively to reality, that is, the rising demand of those we aim to serve to be a part of

¹⁰⁴ *Ibid.* Garvin added that “[a] new study planned by the Center may be of interest to the Coalition and, if the group chooses to participate, may ‘break the ice’ in this relationship. If not, we may be faced with the question of establishing relations with other community groups in that part of Manhattan (the Health Committees of Planning Boards 7 and 10, for example) in order to broaden our contacts throughout the geographical area of our concern.”

¹⁰⁵ *Ibid.* The report cited two examples. The first was “the involvement of Mrs. Ann Brunswick with the Harlem Adolescents Project which has sparked by Harlem Alliance members and the consumer education courses at Harlem Hospital arranged by the School of Public Health in conjunction with the Harlem Alliance.” The second was Dr. Lloyd Novick’s contribution to building constructive relationships with the Alliance. He “won the respect of this organization during his work with the District Health Department, and for a period he regularly attended its executive board meetings.” More recently, the Center held an exploratory session with the group to discuss “our possible cooperation in incorporating their proposal for a planning grant for their adolescent health care project in our own child health care proposal.” Another meeting with the Alliance and the Harlem Hospital Community Board was set for a later date “to iron out problems of communication, at which time we anticipate progress.”

¹⁰⁶ *Ibid.*

decision-making.”¹⁰⁷ Although at the time of this report, Ms. Garvin has served only several months as a ‘community liaison,’ her assessments were remarkably consistent with the criticisms made by the community organizations themselves. The groups indeed questioned the Center’s emphasis on research, its institutional and class interests, as well as its ability to see that its findings actually influence the health care system. The issue of ‘formal participation’ was indeed a central one for community organizations because, as they frequently said, they were not terribly interested in an ‘advisory role’ which can all too easily be used as ‘false testimony’ that the community participated.

For a period of time following the Report there emerged an impression on the part of the community organizations that their formal membership in the Center’s Executive Committee would soon be realized.¹⁰⁸ Although some community leaders still wondered if the Executive Committee had real power over the substance of the Center’s work and whether “membership on the E.C. would help the community guide the direction of the Center’s projects,” they agreed to take the necessary steps to achieve representation.¹⁰⁹ For its part, the Center’s leadership was apparently

¹⁰⁷ *Ibid.* In comparison, the Center’s official report for 1973 described the situation in somewhat sunnier terms, saying that “[a]lthough sound working arrangements and mutual trust are still not at hand, substantial progress has been made.” It also gave scant details of past efforts, but had much to say about the general approach and inevitable differences. (CCHS Annual Report 1973, “Community Interaction Area,” p. 16.)

¹⁰⁸ “Meeting on CCHS – October 31, 1973,” (“Present: Joel Rothschild, Marshall England, Naomi Shaw, Rick Andreas, Gino Crocetti, Brian Bookbinder, Judy Wicks” [Wicks was a representative of the CCHS. – O.P.]). Interestingly, the community representatives became convinced at this point that “the fight [for community representation on the Executive Committee] was really with the Board of Trustees, not the CCHS.” Although this impression was apparently formed following a meeting with the Center’s representatives, exactly how it came about is unclear. The community organizations’ anticipated next steps were indeed oriented at Columbia’s Trustees.

¹⁰⁹ *Ibid.* The immediate steps to be taken were to “consider the formation of a Subcommittee or Advisory Committee,” request official information on the extent and nature of Executive Committee’s powers, and “request permission to send observers to the next E. C. meeting.” Dr. Rothschild felt that “what would be ideal would be a reorganization of the Executive Committee to make it a true governing body and to have a dual policy-making role for consumers and providers.” Mr. England agreed that “what was needed was to get the Board of Trustees to agree to dual policy making” and that “consumer representatives should be no less than providers on the E. C.”

preparing to extend an official invitation to community representatives to attend the meeting of the Executive Committee with a view towards establishing formal membership.¹¹⁰

Just a month later, however, strong internal opposition to any form of community representation on the Center's Executive Committee came from an unlikely source, Dr. Lythcott. In a confidential letter to the Acting Dean of the Medical School and Vice President for Health Sciences, Dr. Lythcott wrote that he had been following for a while the development of the relations between the community and the Center and was very distressed at the course it was taking since the appointment of Mr. Joseph Terenzio as the President's Special Advisor on Community Affairs. He was concerned that "in the absence of our taking an official position as an administration (from which we could negotiate, if necessary), while the community is developing its own position and in the absence of certain facts that we may find ourselves dealing from a position of weakness rather than strength when the ultimate decision about relationships must be made." His own position was that:

... C.C.H.S. is an academic arm of the Health Sciences campus, not unlike the Institute of Nutrition, the Institute of Human Reproduction, the Cancer Center, the proposed Heart/Lung Center, etc. Within this context, then, the policy directions for the Center are developed by the Director in concert with the Vice

¹¹⁰ Two somewhat different understandings of the events appeared in internal communications. In one, Dr. Bryant alerted the School's administration "to the likelihood of community representatives approaching the Board of Trustees of Columbia University asking about the lines of responsibility and authority of the Center for Community Health Systems." In his words, "[t]he point behind this inquiry has to do with the possibilities of community governance of the Center and the reasons why this would or would not be acceptable to the University." In light of this development, "the Center staff together with George Lythcott and Joe Terenzio will be meeting again soon to consider the next steps in this dialogue with the Community." (Bryant to Marks, Tapley, Lythcott, Terenzio, December 5, 1973.) A month later, however, a memo regarding an invitation to the community representatives to sit in on the Executive Committee's meeting conveyed a different understanding. Here, the issue discussed was that of a possible inclusion of several community representatives on the Executive Committee or even a "[s]eparate entity of community representatives to function as an advisory adjunct to Executive Committee," not of placing the Center under public control. [Garvin to Bryant, Ginsberg, Lythcott, Novick, Prof. Piori (sic), January 4, 1974.]

President, the Dean and other administrators and faculty as designated by the Vice President. ... Since the C.C.H.S. deals with many matters that directly affect the community in the development and execution of it's [sic] (C.C.H.S.) programs, the community should serve as a resource to the Center and clearly should have an advisory role. This role of the community can under no circumstance be extended, however, to setting policy for the Center or, as some have suggested, put the C.C.H.S. under public governance.¹¹¹

He had tried, he wrote, "to make this point to Jack Bryant and Joe Terenzio on several occasions, but [he was] not sure that either, especially Joe, really understands this basic premise." In this case, "Joe's understanding [was] especially important since he [was] the person who 'negotiates' for the University with the community." Thus, there was an urgent need for the administration to "meet with Joe Terenzio, and Jack and Vicki Garvin and give them clear guidance as to *the position from which we will not move*."¹¹²

Dr. Lythcott's insistence that CCHS was not unlike other centers and institutes at the medical school was telling. After all, none of the three centers mentioned presupposed community participation as a part of their mission or functioning. An advisory role – a function which the community groups specifically rejected as contrary to the community's interest – was all that would be offered.

Two years after its launch, then, the Center's relations with community organizations hit a dead end.¹¹³ If Columbia's initiative failed to meet the community demands, could it at least do something constructive as a resource for the established health care institutions?

¹¹¹ Lythcott to Tapley and Marks, January 14, 1974.

¹¹² *Ibid.*, emphasis added.

¹¹³ The archival files pertaining to the community health planning initiative contain literally no documents pertaining to community relations after this date.

Health Planning and the Hospitals

Securing the interest and cooperation of major health care providers was the second great challenge for Columbia's health planning initiative. Although new forms of health care organization – like the neighborhood health centers – had been actively tried during this period, CCHS had been oriented from the start to working with and through the Columbia-affiliated hospitals, hoping, no doubt, to use its formal institutional connections to foster its mission. The fact remained, however, that CCHS was launched as an endeavor of the Medical School and not as a joint undertaking between the School and its affiliated hospitals and possible difficulties with the hospitals were noted early in the planning process. Still, as the Center was launching its first project – the Emergency Services study – its leaders were hopeful that they would be able to secure the active interest and participation of the affiliated hospitals. In Dr. Marks' words, emergency care was "a perfect area for initial involvement," not least because it was "a universal problem affecting all of the affiliated hospital and the communities they serve."¹¹⁴

The optimistic assumption of the hospitals' interest was soon placed in doubt. The cooperation of Columbia's primary affiliate, Presbyterian Hospital, was especially problematic. Although agreeing to serve on the Center's Executive Committee, Presbyterian's Executive Vice-President, Mr. A. J. Binkert, carefully distinguished his own participation from the Hospital's institutional commitment. "It is my understanding," he clarified in a note to Dean Marks, "that any proposal from this group (ORPCHS) involving the hospital, its professional staff, and the care of patient would first come the hospital and go through the appropriate administrative and

¹¹⁴ Minutes, Executive Committee Meeting of the Center for Community Health Systems, December 21, 1971. The immediate objective was "the improvement of Emergency Care, using Harlem, St. Luke's, Presbyterian, Delafield and Roosevelt Hospitals." It was hoped the study would pave the way toward "restructuring and perhaps integrating existing services."

professional channels, particularly the Medical Board, before any commitments are made.” The Hospital’s administration, he explained,

is spending a great amount of time trying to solve current operating and financial problems which are certainly acute. The hospital’s patient care is totally underfinanced at the moment and we are faced with severe problems and decisions.¹¹⁵

Although Presbyterian’s troubles seemed like the very tasks the CCHS was created to work on, the Center’s help was not actively sought.

Six months later came another less than encouraging sign when Presbyterian’s Director of Emergency Medical Services applied for foundation funding for a project very congenial to the CCHS mission – without seeking either the Center’s participation or even mentioning it as a resource.¹¹⁶ More than a year later, with a new person in charge of the Hospital’s outpatient and emergency services, CCHS still had not received any promises of cooperation. The new director of ambulatory medicine expressed interest in CCHS, but noted that the uncertainties of fiscal and administrative arrangements prevented him from clearly committing to a certain level of participation in the work of the Center.¹¹⁷

With minor exceptions, the Center’s mission to involve the affiliated hospitals in the restructuring of the ambulatory services never got off the ground. By the middle of the decade, the erosion of interest on the part of the hospitals had reached its lowest point. Although the elusive promises and the barely veiled brush-offs were the

¹¹⁵ Binkert to Marks, April 21, 1971. Similar, if more irritated letter was sent earlier to Dr. Canfield, Binkert to Canfield, February 25, 1970.

¹¹⁶ John V. B. Dean, M.D., Director, Emergency Medical Services, to George P. Berry, M.D., 216 Nassau Hall, Princeton, NJ, July 14, 1971. (Cover letter and preliminary proposal for consideration by the Whitehall Foundation). The project’s aim was to “develop a demonstration model of a primary medical care system of the highest quality in the setting of a large metropolitan teaching hospital in behalf of patients with varied ethnic, financial, and environmental backgrounds.”

¹¹⁷ Bryant to John L. Roglieri, Director of the Division of Ambulatory Medicine, Department of Medicine, January 4, 1973; Roglieri to Bryant, March 14, 1973.

typical manner for conveying the refusals to participate, the Executive Vice President of St. Luke's Hospital chose at some point to state his reasons openly. Responding to the call from the Medical School concerning St. Luke's possible financial support of CCHS, Mr. Gary Gambuti wrote that his first reaction was that "there is a real need for the Center," particularly if its work emphasized "more practical applications, especially in relation to the problems of the affiliated hospitals." Specifically:

the delivery system in terms of ambulatory care; the division of the West Side into catchment areas for each of the affiliated hospitals and the provision of primary care and the sharing of specialty clinics; the duplication of unnecessary services; the organization of teaching services vis-a-vis the impact of a national health insurance; the increased cooperation between institutions in relation to the decreasing research dollar; the need for brainstorming sessions in terms of full-time hospital based physicians versus billing for third party payment; etc.

He was also in agreement with the premise that "the involved institutions due to the volume of services rendered, their quality and prestige, have a quasi-moral obligation to objectively examine what they are doing, make improvements and report these in an academic fashion to the community at large."¹¹⁸

His second reaction to the Dean's request, however, was uncertainty as to whether St. Luke's would "get a return for the investment it was asked to put in the School." The question was particularly sensitive since, at present, the Hospital simply did not have "an extra \$50,000 in the budget." To make an investment in CCHS, it would "either have to take [the money] from somewhere else or project the year-end deficit to be that much greater."

¹¹⁸ Gary Gambuti, Executive Vice President, St. Luke's Hospital Center, to Donald F. Tapley, Dean, College of Physicians and Surgeons, April 9, 1975. Copies of this letter were forwarded to the Chairman of the St. Luke's Hospital Board of Trustees, as well as the Executive Vice President of the Roosevelt Hospital and Vice Chairman of the Board of Trustees of the Presbyterian Hospital.

One solution mentioned was the “buy-sell” concept; that is, we contract from the Center for those services needed and pay for them. While this has great administrative appeal from my point of view, I can understand your reluctance since it would be almost impossible to stabilize a budget and maintain the necessary growth and development in staff that the Center needs.¹¹⁹

Responding to the dilemma, Mr. Gambuti finally decided to examine more closely “the role of the Center, its organizational structure, and its potential for influencing change.” His conclusions, alas, were not encouraging and delivered, in an abbreviated form, an analysis of the Center’s political position which its leaders had studiously ignored since its planning stages.

First, the Center is located in the University. By its very nature it will always be and probably should be, somewhat theoretical. Secondly, the financial problems of hospitals and the whole health system are so great and complex that at the present time the only changes hospitals are going to make are those to help maintain solvency. These changes will be individually related to the circumstances in each hospital. Any major changes in the delivery system will be governmentally and politically oriented. The delivery system will be changed by the advent of National Health Insurance and the implementation of 1974 Health Planning and Resources Development Act. Finally, and probably the most pathetic of all, is the realization that even if the Center made a study on duplication of services or on any other significant area where the affiliated hospitals through cooperation might reduce costs and at the same time deliver a better service, the Center, being located in the University, has no “clout”. The institutions involved have not shown, at least up to this point, their willingness to phase out programs or to cooperate significantly on any logical basis. This also will not come about until we are forced to do so by the government.¹²⁰

In light of this understanding, he was sorry to say, Mr. Gambuti could not recommend to St. Luke’s trustees the commitment of \$50,000 per year over four years for the CCHS. The Hospital, in his reckoning, was already subsidizing the Medical School in the amount of over \$200,000, which included losses incurred by the

¹¹⁹ *Ibid.*

¹²⁰ *Ibid.*

Hospital for the Columbia Health Service, free space for classes and offices, as well as direct financial assistance to the Nursing School.¹²¹

Although clearly colored by some ‘accounting’ issues between the institutions, Mr. Gambuti’s analysis of the CCHS was both incisive and principled. It was also, in its main thrust, not new. Although repressed during the planning and launching stages of the initiative, this political, cross-institutional understanding of health care reform had been increasingly voiced as a major critique of the Center, by individuals both outside and inside its formal structure. Community groups, as well as the Center’s community liaisons, repeatedly wondered if the Center had thought out realistic mechanisms, by which to affect actual change within health care system. The need to reach out to other institutions (preferably with something other than urgent funding requests), as well as the need to engage with the political system, were also frequently raised issues.¹²² Not only did the Center fail to engage with other institutions and the

¹²¹ *Ibid.* Similar, if less explicit, response was received from the Lenox Hospital. In response to the CCHS letter proposing collaboration, Spencer Albert, Director of Community Affairs wrote to Mrs. Nora Piore: “My feelings at this point are that there is probably no mutually advantageous project on which we can work.” (Spencer Albert, Director of Community Affairs, Lenox Hill Hospital to Piore, January 11, 1974.)

¹²² During one particularly heated meeting of the Executive Committee, several members expressed their dissatisfaction with the Center’s neglect of the core issues, namely the financing of the health care for the indigent. Mr. Terenzio, in particular, insisted that financing solutions had to be sought on the state or national levels, proposing that the Center “should be addressing [itself] to developing a consortium of various health care institutions that could present a model proposal for delivering health services to the state.” Dr. Ginzberg countered that “it would be hard for the Center to get some leverage on new designs without simultaneously providing for some kind of new arrangements among financing agencies” and without such new arrangements “the situation [was] frozen.” Mr. Terenzio’s suggestion, he thought, “would engage you in a very serious and complicated organizational consortium arrangement for the production of new relationships and services to which you would hope to tie research.” Although skeptical, Dr. Ginzberg agreed that it was questionable “whether you can do any research [of the type that the CCHS was set up for] unless you can also get very sizeable new arrangements among providers.” Mr. Terenzio replied that it could indeed be “very complex but we first must define parameters of what we are trying to do.” If CCHS wanted to engage in actual planning, then the interaction on the broad inter-institutional and political level was unavoidable. “If we are concerned about screening programs,” he added, “then we confine our activities to a smaller scale.” (Minutes of the Center for Community Health Systems, Executive Committee Meeting, February 20, 1973.) Although Dr. Ginzberg generally supported the narrow, pragmatic approach, even he was beginning to urge engagement with other institutions and the political system. Criticizing the Center’s lack of self-direction and passive acceptance of outside projects, he insisted that is CCHS

political structures, its record of building internal relations was likewise less than impressive. Aside from Pediatrics, CCHS has not joined any other clinical departments in any programs geared toward changing “their teaching and service activities.”¹²³

Despite concerns about the hospitals’ increasing lack of interest, the Center’s leadership failed to take the deeper message of these critiques to heart. Instead of looking hard into the Center’s mission, capacities, and methods, the new Director’s reaction to the lack of enthusiasm from the affiliated hospitals was to reach for ultra-traditional ways of doing academic business – through private deals with members of the social elite. Distressed over “the erosion of support from those institutions which were said to be committed, [like] St. Luke’s, Roosevelt and Harlem,” Dr. Weiss thought that “the only way we can get this solved is to set up a meeting, probably a dinner meeting, at which have Magill (sic) invite Eaton, Choate, Kerst, and the

wanted to “make a real difference,” it would have to “be able to convince the City to introduce some ... significant changes in how it uses its health resources in the Washington Heights area” and “be instrumental in developing new linkages among key institutional providers.” These, Dr. Ginzberg realized, were ambitious aims, each being “a formidable, perhaps an impossible task,” but “unless one tries,” he argued, uncharacteristically, “one will never know one has failed.” (Ginzberg to Lythcott, October 31, 1973.)

¹²³ Ginzberg to Lythcott, cc Bryant, Marks, December 26, 1973. Toward the end of 1974, internal critiques and disagreements appeared to have prepared the way for change in its leadership ranks. Dr. Allen S. Ginsberg was appointed Deputy Director of CCHS and the search for a new Director of the Center was underway, with active participation of the Robert Wood Johnson Foundation. [The first mention of Dr. Ginsberg’s appointment as Deputy Director is in Allen S. Ginsberg, Deputy Director of CCHS to Donald F. Tapley, Associate Dean of Faculty Affairs, P&S, January 2, 1974. Several notices, dated February 24, 1975, announced Dr. Bryant’s request to be relieved from the duties of the Director of CCHS and appointment of Dr. Allen Ginsberg as Acting Director. Dr. Robert J. Weiss was recruited to serve as the Center’s second Director, beginning in the Fall of 1975. (“Report of the Dean of the Faculty of Medicine,” CPMC Annual Report 1975.)] Detailing his views on the problems facing the Center, Dr. Eli Ginzberg told the Foundation’s Vice President, Miss Margaret Mahoney, that “with relatively few exceptions,” the present CCHS staff was “not of the quality it should be” and was also “much too large.” In his view, the Center would be much more successful with “a relatively small core staff of strong people with a continuing interest in social medicine,” capable of being “the PI’s [principal investigators] of significant ongoing problem-oriented research.” The choice of a new director was crucial and this person “must be first capable of running a quality research staff, not be an empire builder and have the potentiality for linking both the clinical departments and the social science departments.” (Ginzberg to Miss Margaret Mahoney, Vice President, The Robert Wood Johnson Foundation, May 13, 1974.)

Presidents of the Boards of Trustees and administrators of St. Lukes and Roosevelt.”

If the Medical School’s top brass attended this meeting and if he “made a presentation of the problems facing the hospitals, the University’s commitment to the solution of the problems and the need for continuing support by the hospitals as clients of the Center, Dr. Weiss reasoned that there might be “a chance to really bring it off.”¹²⁴

For Dr. Weiss, well-crafted presentations and private deal-making could well substitute for the broad political changes the hospitals needed to induce them to collective reform. “The hospitals are facing bankruptcy,” he admitted, “and I believe we can bring Blue Cross and the United Hospital Fund along if the hospitals make a commitment with the University.” The new director was quite sure that at least one potential donor “would come forward with the money for support of specific projects” and “the same would be true from many other sources.” Although certainly ‘concerned’ with the problems facing the hospitals, Dr. Weiss had a few pressing issues of his own. The Center was running out of money and his worry about the hospitals was “intensified by the fact that the Health Services grant will be greatly influenced by the ability of the Center to demonstrate that it has real clients i.e., the hospitals and Blue Cross.”¹²⁵ His proposal, it seems, has thrown the Center’s problems together the problems of financing health care for the indigent, with little distinction between the two.¹²⁶

¹²⁴ Weiss to Schoenberg, June 18, 1975. The proposed invitees to this meeting were high officials and important benefactors of Columbia-Presbyterian: William J. McGill, President of Columbia University, Thomas H. Choate, Chairman of the Board of the Trustees of the Presbyterian Hospital, Fredrick M. Eaton, Trustee and Chairman Emeritus of the Board, and Richard N. Kerst, the Hospital’s President. (CPMC Annual Report 1975.)

¹²⁵ *Ibid.*

¹²⁶ In the Fall of 1975, a deficit of \$300,000 per year was projected if no new money was found. (Weiss to Tapley, Schoenberg, Putney and Toy, October 2, 1975; Weiss to Tapley and Schoenberg, April 12, 1976.)

Scholarship and Proposals

Whether the criticisms of the Center's failings to engage other institutions and the political system were fair in view of their human and financial resources is hard to say. But even the Center's scholarly output was unimpressive. The findings of the Center's two major studies reported in the Center's Annual Report for 1974 are case in point. Even the typically inflated language characteristic of the official reports failed to prevent the impression that the studies' findings were, at best, duplicative of the already existing knowledge and, at worst, not very useful or usable. The "Community Hospital Ambulatory Care Project," requested by the Robert Wood Johnson Foundation, yielded results that could not be distilled even for the purposes of the annual report. "The field of hospital ambulatory care," read the abstract, "appears to be in a considerable state of flux; experts differed in their experiences and opinions, and the subject did not readily lend itself to any neat division of issues and problems." The project, which now appeared under the name of "Health Care for the Poor," reported findings that were commonly known and assumed at the outset of the community health care initiative. "The work of the project staff to date," read the report, "supported potentially important findings: (1) a large proportion of the poor and near poor rely on institutionally-based resources for most of their health care; and (2) there are many serious problems with institutionally-based ambulatory care."¹²⁷

Even after the rebuttal from St. Luke's, the main thrust of the Center's scholarly work became more, not less technocratic. A short prospectus prepared for the urgent fundraising effort and entitled "New Directions for the Center for Community Health Systems" registered a notable shift from 'community health care,' which has been the key term during the early 1970s to 'health services research,' a

¹²⁷ CCHS Annual Report 1974, p. 17.

new term designating presumed maturation of a new field of knowledge holding a promise of better health care. With the issue of community participation in the Center's work nowhere to be found, the promise of the new approach was described in terms of the knowledge it has allegedly already produced.¹²⁸

"In its relatively short history," asserted the CCHS prospectus, "health services research has produced principles which should form the basis of future efforts to restructure the health care system and resolve some major problems."

Document after document has confirmed the inadequate accessibility of ambulatory health care; the high cost of delivery of all health care; and the fragmentation of the delivery system. And from comprehensive efforts like the British National Health System or the Swedish system, it is clear that no single model has yet been devised which provides a total answer for the myriad of interlocking problems confronting the health care system. It is also clear that the financing of the health care system is beset by, and causes, many problems. These multiple problems will not be solved by a single step such as National Health Insurance.¹²⁹

¹²⁸ "New Directions for CCHS: A Prospectus," January 1976. The prospectus was described as "a document to be used in support of the fundraising effort for the Center." (Weiss to Putney and others, December 11, 1975.) Whether the criticisms of the Center's failings to engage other institutions and the political system were fair in view of their human and financial resources is hard to say but even the Center's scholarly output was unimpressive. The findings of the Center's two major studies reported in the Center's Annual Report for 1974 are case in point. Even the typically inflated language characteristic of the official reports failed to prevent the impression that the studies' findings were, at best, duplicative of the already existing knowledge and, at worst, not very useful or usable. The "Community Hospital Ambulatory Care Project," requested by the Robert Wood Johnson Foundation, yielded results that could not be distilled even for the purposes of the annual report. "The field of hospital ambulatory care," read the abstract, "appears to be in a considerable state of flux; experts differed in their experiences and opinions, and the subject did not readily lend itself to any neat division of issues and problems."¹²⁸ The project, which now appeared under the name of "Health Care for the Poor," reported findings that were commonly known and assumed at the outset of the community health care initiative. "The work of the project staff to date," read the report, "supported potentially important findings: (1) a large proportion of the poor and near poor rely on institutionally-based resources for most of their health care; and (2) there are many serious problems with institutionally-based ambulatory care." (CCHS Annual Report 1974, p. 17.)

¹²⁹ "New Directions for CCHS."

Restatement of the problems commonly known for over a decade and a resounding affirmation of the usual ideological position on public welfare programs was apparently all that the science of health services research had to offer.

“The urgent, overriding present requirement,” read the prospectus, “is to design, and experiment with, a number of pluralistic models.” Experimenting with one system of health care provision is a formidable task but experimenting with highly disparate, fragmented systems, if they can even be called that, comprising American health care could strike one as a hopeless proposition, not to mention that mere experimentation held no promise of institutional change in accordance with experimental findings.¹³⁰

The survival of the largely private, two-class system of care – for which ‘pluralistic’ was a word of choice here – was a foregone conclusion and the Center’s mission was perfectly calibrated to this “inevitability.”

Given the heterogeneity of patients and providers, we must develop guiding principles which can be generalized to different organizational structures, with different manpower mixes, financing arrangements, and populations. This Center sees as its primary mission the development of these principles, which will emerge only from carefully planned and evaluated demonstration and experimental projects along a number of lines – befitting the inevitability of a pluralistic approach, and incorporated in whole or in part into the actual delivery system. We are dedicated to implementation of research results in operating agencies; publication is a necessary but not sufficient goal.¹³¹

Some of the elements of the ‘inevitably pluralistic’ approach were already emerging, thanks to the Center’s indefatigable efforts. For subscribers of a health insurance company and University students and their families, comprehensive care within the framework of a health maintenance organization was in the works. For the urban

¹³⁰ *Ibid.*

¹³¹ *Ibid.*

poor, there was being developed “a model of pediatric and perinatal care provided in the inner city through the use of *trailer-based clinics* placed at readily accessible sites.”¹³²

Nevertheless, St. Luke’s Vice President’s candor may have had some effect on the Center’s approach after all. A year later, the Center prepared a proposal to address the problems with the out-patient services at the Columbia-affiliated hospitals. The document was notable for its unusual openness in regard to the role of class inequality in precipitating the current crisis. The proposal’s political awareness was reminiscent of some of the early views which emerged in connection with the community health planning initiative. The solutions it offered, however, were much less radical than its analysis of the problem.

Contrary to the early hopes for substantial improvement of hospital-based outpatient clinics, on which the urban poor increasingly depended for most of their primary care, in the middle of the decade the hospitals’ strongest incentive remained to minimize care of those who cannot pay. In the absence of political solutions to raise the share of resources spent on the health care of the poor to the level comparable to privately-insured patients, inner city hospitals were keenly interested in reducing the share of the ‘medically indigent’ in their patient mix. This understanding formed the

¹³² *Ibid.*, emphasis added. The degree of ideological ‘crafting’ of the prospectus to the supposed views of the potential sponsors is hard to ascertain but it is notable that Dr. Weiss had advised against the Center’s participation in any studies or projects premised on the need to move toward a one-class system of health care. Apropos one such proposed project, originating from an associate at the American Association of Medical Colleges, Weiss wrote: “I think that it would not be productive at this time for us to suggest participation in the program because of the political factors involved and the limited commitment by the hospital to the concept of one class care. It would involve a major effort for very little in return in my view. I know [the author of the project]. He is a pleasant and bright young man, but I find the program not very sophisticated in its approach.” (Weiss to Tapley, October 3, 1975.)

basis of the Center's proposal, developed in the Fall of 1976, aimed at rekindling relationships with the affiliated hospitals.¹³³

Gross inadequacies of health care available to the urban poor, which in a 'health services research' view were attributable to the loss of office-based practitioners, overcrowded hospital outpatient departments and general disorganization of health care systems, had their corollary in the problems experienced by the urban private hospitals. According to the proposal, "[a]ll of the Columbia hospitals [were] experiencing difficulties in maintaining a steady flow of private patients and an erosion in the ranks of attending physicians in private practice in the upper class and upper-middle class sections of the city." The urban poor, on the other hand, made heavy "use of hospital-based outpatient departments and emergency rooms for large amounts of primary and non-urgent medical care." This constituted not only an inappropriate use of resources, but also created substantial losses for the hospitals due to the burden of treating the un- and under-insured and the hospitals' inefficiency in providing routine care.¹³⁴

Subordinating the problems of the inner city poor to those of the urban hospitals, the Center's proposal defined the task as follows: "to establish a system of ambulatory care which will serve both the inner city population ... as well as providing [for the hospitals] the access to the market of middle and upper-middle income patients in order to retain a mix of patients in our Columbia hospitals." The key to the solution lay with the practicing physicians. "It is clear," the proposal stated, "that physicians are motivated and rewarded by economic and other considerations."

¹³³ "Tentative Plan for Development of Ambulatory Care Services, Columbia-Affiliated Hospitals" undated, probably October, 1976.

¹³⁴ *Ibid.*

A major source of gratification in the practice of medicine is the personal interaction between physicians and patients. Middle class physicians have difficulties in establishing this kind of interaction with lower class patients with totally different life experiences and concerns. It is impossible to expect that even the most highly idealistic physician will remain in practice in the inner city seeing multi-problem patients 8 hours a day, 5 days a week all year long.

This hypothetical inner city physician, then, faces the same problem as the inner city hospital: too many lower-class patients, treating whom is neither pleasant, nor profitable. The solution is “to provide a way for physicians as well as hospitals to be exposed to a mix of patients so as not to be overwhelmed by the problems of a single class with whom they have difficulty identifying on a personal level.” Theoretically, the hospitals should be more keenly interested in implementing one or another kind of a solution to this problem because, unlike individual practitioners, they cannot very easily move out of their present locations.¹³⁵

The proposal’s specific suggestion called for an establishment of a network of ambulatory care centers around the Columbia-affiliated hospitals under separate non-profit management. The centers would be located in several parts of the city, such that, together, they would attract about equal numbers of middle- and upper-middle class patients, on one hand, and low-income patients, on the other. One of more groups of physicians would be hired on a salary basis and with limited hospital privileges to staff this network. The work assignments would be arranged in such a way that “physicians in the group would spend two days one week in an upper middle class or middle class ambulatory center, and the following week would reverse the time spent.” Laboratory test and specialty consultation support would be provided by the hospitals, while the centers, in turn, would “ensure a steady flow of patients from a population group large enough to keep the hospitals operating at optimal capacity.”

¹³⁵ *Ibid.*

Such a system “would permit physicians to live outside of the City and still maintain the kind of practice that would cover the population.” Innovations such the use of nurse practitioners for home visits in the middle class areas where safety in not a major concern ... could also be experimented with.”¹³⁶

The main advantage of the proposed system for the hospitals was the opportunity of “divesting themselves of what is totally different business than the inpatient business – namely ambulatory care – and assuring better stability as well as a proper share of the market.” Apparently, the proposal was inspired by the success of a for-profit management group – the American Practice Management, Inc. – which has established Medicaid clinics under such a system and offered management with private capital raise in the commercial money markets. If this company could do it, said the proposal, “then a non-profit corporation ought to be able to function delivering better care without its goals being distorted by a profit motivation.” American Practice Management has already approached St. Luke with a proposal for establishing and managing the hospital’s primary care center and the firm’s materials, including some financial statistics, were appended to the proposal. Essentially, the hospitals were encouraged to enter into a variety of a ‘Medicaid mill’ business, albeit with purer motivations expected to prevail even in the face of their dire fiscal situation.

Why would middle-class, let alone upper-class, patients choose to utilize the ambulatory centers, instead of their regular hospital-affiliated, office-based physicians, remained unexplained. Clearly, the social and professional prestige of the physicians who were to staff such ambulatory clinics would be much lower than that of most current hospital-affiliated practitioners. Even if their practice among the lower-class

¹³⁶ *Ibid.*

clientele were to be limited to half their work time, only the less advantaged physicians – either recent immigrants or those coming from lower- and lower-middle class backgrounds – would likely be amenable to recruitment into such arrangements. If these questionable presuppositions did not hold, the only thing left of the Center’s proposal was a not-so-subtle recognition that the private hospitals might want to divest themselves of ambulatory care for the poor in any way they could.¹³⁷

The proposal’s focus on the class issues involved in urban health care crisis was an explicit admission that the Center’s professed concern with health care services of Upper Manhattan could not be understood without the reference to the structures of socio-political inequality. The Center’s record in this task, however, was patchy at best. The early, class-conscious understanding of urban health care crisis, articulated primarily by Dr. Canfield, was suppressed in favor of a politically ‘neutral,’ technocratic approach. Explicit invocation of class issues by community organizations – pertaining both to health care problems and the Center’s own function – were for the most part simply ignored even as the Center’s researchers found it difficult to articulate the health situation of the Upper Manhattan’s poor and minority populations in non-judgemental, class-neutral terms.¹³⁸

¹³⁷ In a paper delivered at the NYAM symposium, which touched on many of the same themes as the proposal, Dr. Weiss pointed out that “[d]espite our efforts to recruit and train students from deprived socio-cultural backgrounds, they are no less middle class when they finish their training than their classmates, and are not anxious to return to the inner city to spend their professional lives.” There was a basic problem, then, with creating physicians culturally un-alienated from the lower-class patients because it was an undisputed accomplishment of the American medical profession that the physician was by definition in the middle class or higher in his cultural and economic status. Thus, the only physicians willing to work in the low-class neighborhoods were immigrant doctors trying to get their footing in this country. They too, however, did not aspire to stay in the ‘Medicaid mills’ forever. (Robert J. Weiss, “The New Primary Care Physician,” presented at the NYAM 5th Symposium on Medical Education, “The Medical School and Its Surrounding Community,” October 14, 1976.)

¹³⁸ In a telling incident, the final report of the study entitled “Unscheduled Visits to Four New York city Columbia-Affiliated Hospitals,” for instance, had to be redone to present “a non-judgemental overview of socio-demographic, operational and medical characteristics of patients making visits to College affiliated hospitals.” (Ginsberg to Tapley, January 2, 1974.)

Conclusion

In retrospect, the Center's unexpected return, after the middle of the decade, to 'straight talk' about the role of class in structuring health care was too little, too late. The Center's reputation as an insular research outfit, oriented toward discrete and preferably paying projects, was already made. The Center repeatedly argued that socio-economic problems were outside of the health system as such and, therefore, outside of the Center's activity. It had also refused to align itself with those external groups and institutions, whose cooperation could have insured more principled and effective activity. Even this late awakening was still largely deaf to the repeated suggestion that the Center's work cannot be limited to technocratic tinkering with separate services of separate institutions but had to extend to inter-institutional, broadly social, and political problems.

Although structurally complicit in the fragmented, chaotic system of health care delivery, even some private hospital leaders knew better than to tweek with individual services and institutions one at a time. Numerous criticisms pointed the Center toward a broader view and a wider aim. Engagement with the city government, state agencies, hospital associations, professional societies – any of these would have been better than 'courting' the individual hospitals. But even if CCHS did not have such capacities – due to limited human or financial resources, say – there was still a better option of simply advocating, in a scholarly manner, approaches that might have actually worked. Alas, the Center preferred to work on supposedly 'concrete' and 'practical' projects that in practice rarely went beyond duplicative research.

Most of the problems which plagued the Center had been foreseeable before the launch, in the highly compromised manner and result of its design. Was it inevitable? Hardly.

Entrusting the conceptualization of the initiative to the people who did not have much to gain from it, career-wise, would have been helpful.¹³⁹ Establishing a clear and open process of proposal-making, discussion, and review would have ruled out some of the uglier moments of the story. Initial reliance on internal funds, rather than making the launch of the initiative dependent on receipt of external funding, could have also eased the need to conform to external agendas. Such a decision would have also signaled that the initiative was undertaken upon a principled internal decision, rather than a desire to get a fair share of the new source of grant funds. Finally, cultivation of institutional mechanisms and incentives for internal criticism, democratic decision-making, and equitable distribution of power, participation, and rewards would all have been beneficial, even if impossible to achieve in the short-term.

A conspicuous lack of self-reflection and criticism – both during the planning and consequent functioning of the Center – was perhaps the most remarkable element of this university-based initiative. Contrary to conventional assumption, the most intense censure actually occurred in the narrow circle closest to the leadership of the initiative. The further away one went from the small group of contenders seeking to control the initiative, the more likely it was that the really important questions were raised. Clearly, the career- and power-conflict which surrounded the launch of the Center was poison to free thinking and expression. The prototype of an open, democratic process, embodied in the work of the Center's Executive Committee, suggested a viable way of overcoming the pathology of the personalistic, secretive, career-driven mess, in which the Center's planning was caught up.

¹³⁹ This measure was implemented to some extent in the creation of an Executive Committee to oversee and advise CCHS but it did not come into effect until after the initiative's conceptualization was completed.

Without question, the most productive moments of this story were those critical understandings that came out from the confrontation between the Center and its internal interlocutors – the community organizations and the hospital representatives. To be sure, these exchanges did not yield immediate palpable results. Despite several opportunities, the Center failed to own-up to the real motivations and limitations of its work and to adjust its mission and goals accordingly. In turn, both the angry community organizations and the hard-pressed hospitals did not care for predictable platitudes and questionable promises of the Center's technocratic approach. Still, interactions between the Center, on the one hand, and community organizations and hospital representatives, on the other, were by far the most potentially valuable forums of the entire process, pointing to the value of engaging separate institutions and groups in constructive dialogue.

When viewed in such excruciating detail, this small piece of the larger community health planning movement may seem to blur, rather than sharpen the view of the larger politics. Where did the main lines of cleavage lie? How much of this was so much petty personal scraps? The analysis presented here indeed does not confirm conventional accounts. The assumptions of institutional analyses, which privilege organizational boundaries, are placed in question by the centrality of intra-institutional conflict and general vagueness of institutional boundaries within the sprawling academic medical empires. The verities of traditional class analysis are equally undermined by the narrowness of interstitial divisions activated in this struggle. How do we conceptualize distinctions between hospital administrators, academic physicians at elite private hospitals and those at struggling public institutions, free-floating public health specialists, and 'dissident' academics, like Dr. Rothschild? Clearly, these 'identities' stem neither from the inter-institutional divisions nor from broad socio-economic categories but rather from an infinitely more

nimble matrix created by the interpenetration of basic structures of social mobility and institutional organization. These are precisely those structures in which most struggles occur among occupants of adjacent social positions – in a continuous and spatially diffused manner – rather than between large and differentiated groups. It is also the structure that it tightly interwoven with the basic mechanisms of social discipline, particularly those of the labor markets, educational system, and professional careers.

The account presented here mitigates, however, against the cynical structuralist interpretation of the course and outcome of social politics. To link the motivations of the main actors to their institutional positions and their actions to the structures in which they act is not to suggest the necessary or binding relationship between them. To champion organizational change, as most of our protagonists had, was still an individual choice, involving considerable risks and uncertain pay-offs. In the upwardly mobile professional world, one is hardly ever ‘tied’ to one’s place and a career advancement by conventional means – not by organizational critique – is unquestionably the faster way to move out of the disagreeable positions and departments. Thus, the choice to speak up, to lead the movement for community health planning, was just that, a choice, and deserves respect for going considerably beyond simple self-interest.

Not only individual agency, but also the structural features of *particular* institutions – and not only those of the larger society-wide structures – constituted intervening variables in the course and outcome of this struggle. It is precisely the contrast between the courage and honesty of some of the individuals and the corrupt structural channels and mechanisms of decision-making that is so striking. As far as such personal matters can be ascertained, the path that was chosen did not reflect the better sentiments of the members of Columbia faculty which initiated and developed the community health planning initiative. It was, however, strongly favored by the

structure of individual and institutional incentives that permeated their efforts. The account of Columbia's community health planning venture is a cautionary tale about the capacity of professional and academic institutions, as they have been structured during the second half of the past century, to lead their institutions along clear and intended political paths. Viewed in isolation, the Center's role in health care politics may seem fortuitously negligible. When projected across space, embodied in hundreds of similar processes of interaction among academic centers, health care institutions and marginalized communities, Columbia's story ceases to be trivial, pointing to the endemic structural conflicts in the American polity which can not help prevent us from moving forward.

CHAPTER 8

THE NEW (INSTITUTIONAL) CLASS STRUGGLE: ACADEMIC MEDICAL CENTERS AND AMERICAN HEALTH CARE POLITICS

Introduction

In her recent study of feminist politics in the church and military, Mary Katzenstein noted that identity politics – long associated with public action, protest, and advocacy groups – have quietly moved inside institutions. Workplaces, religious organizations, and other institutions of the economy and civil society are now crucial, if less visible, battlegrounds for equality. Identity politics, however, is not the only arena in which institutions have been overlooked as sites of political struggles. The calls for greater attention to institutions have been sounded in the areas of scholarship as diverse as political participation and the welfare state. The problem Katzenstein identifies goes beyond recent trends and identity politics. Institutions where Americans work, pray, and join together have always been important, yet frequently neglected sites of politics and policy-making.

In the study of American welfare and health care systems, this problem is complicated by a tendency to draw the boundaries of the discipline in a way that includes the ‘public’ sphere of government and formal political processes, while excluding the ‘private’ sphere of the economy and civil society.¹ While the institutions and policies of government have been studied extensively, the role of economic and social institutions was largely neglected. The results of this one-sidedness have been especially dire for the study of American health care politics.

¹ The terms ‘public’ and ‘private’ are placed in single quotations marks to indicate that the distinction between these realms has been frequently criticized by scholars working within several orientations of political theory, including Marxist theory, political economy, and feminist thought.

Compared to other advanced democracies, the United States has an extremely privatized system of health care provision and a failure to consider private and non-profit institutions leaves many questions unanswered.

In the last two decades, the narrow focus on public institutions and programs has been increasingly criticized. Several studies have demonstrated that most systems of social provision include both public and private elements and that the American system, in particular, cannot be understood without considering the enormous size of its private social benefits and provider institutions.² This critique is especially germane to the study of American health care politics. The American health care system has become only more privatized and inequitable over the past quarter century. The failed effort to create a national health insurance system in the 1990s has dimmed the prospects for large-scale federal health care reform, while state-level reforms are constrained by limited resources and authority. In contrast, the role of corporate capital and the private sector has grown tremendously, unleashing nothing less than a revolutionary transformation of American medicine.

² For comparative analyses, see: Martin Rein and Lee Rainwater, eds., *Public/Private Interplay in Social Protection: A Comparative Study* (Armonk, N.Y.: M. E. Sharpe, 1986); Gøsta Esping-Andersen, *The Three Worlds of Welfare Capitalism* (Princeton, N.J.: Princeton University Press, 1990); Sven Steinmo, *Taxation & Democracy: Swedish, British, and American Approaches to Financing the Modern State* (New Haven: Yale University Press, 1993); Michael Katz and Christoph Sachsse, eds., *The Mixed Economy of Social Welfare: Public/Private Relations in England, Germany and the US, 1870s-1930s*, (Baden-Baden: Nomos, 1996). Works focused on the United States are: Beth Stevens, *Complementing the Welfare State: The Development of Private Pension, Health Insurance and Other Employee Benefits in The United States* (Geneva: International Labor Office, 1986); Neil Gilbert and Barbara Gilbert, *The Enabling State: Modern Welfare Capitalism in America* (Oxford: Oxford University Press, 1989); Theodore R. Marmor, Jerry L. Mashaw, and Philip L. Harvey, *America's Misunderstood Welfare State: Persistent Myths, Enduring Realities* (New York: Basic Books, 1990); Christopher Howard, *The Hidden Welfare State* (Princeton, NJ: Princeton University Press, 1997); Steven A. Sass, *The Promise of Private Pensions: The First Hundred Years* (Cambridge, Mass.: Harvard University Press, 1998); Marie Gottschalk, *The Shadow Welfare State: Labor, Business, and The Politics of Health Care in the United States* (Ithaca, NY: Cornell University Press, 2000); Michael Katz, *The Price of Citizenship: Redefining the American Welfare State* (New York: Henry Holt, 2001); Jacob S. Hacker, *The Divided Welfare State: The Battle Over Public and Private Social Benefits in the United States* (New York: Cambridge University Press, 2002).

The deepening privatization of American health care poses a challenge to political scientists who have focused almost exclusively on the role of the government and public policy in the health care field. American medicine and health care system have always been more privatized than those of other advanced capitalist democracies and an exclusive focus on public actors and structures misses a big swath of health care politics. In recent decades, however, the government's role in health care may have been even further reduced by the corporate restructuring of medicine and the hegemony of market approaches. The dynamics of path dependence and policy feedback may well ensure that the United States will have a highly privatized system of health care for the foreseeable future.³

Private Institutions, Path Dependence, and Health Care Policy

The concept of 'path dependence' has had a growing impact on social sciences. In economics, where the term was first popularized, "a path-dependent sequence of economic changes is one of which important influences upon the eventual outcome can be exerted by temporally remote events, including happenings dominated by chance elements rather than systematic forces."⁴ The phenomenon of 'increasing returns' provides a central mechanism in path dependence and arises when large fixed costs, learning curves, network effects, or adaptive expectations are involved. Although cases involving technology are best known, economists have applied the concept of path dependence to a wide range of issues, including industrial geography,

³ Historians and sociologists studying medicine and health care have long recognized the highly private character of these fields in the United States. The newest publication by a leading historian of American health care signals an explicit adoption of the hybrid, 'public/private' formulation: Rosemary Stevens, *The Public-Private Health Care State: Essays on the History of American Health Care Policy* (Transaction Publishers, 2006).

⁴ Paul A. David, "Clio and the Economics of Qwerty," *American Economic Review* 75 (1985): 332-337, p. 332.

economic development, and international trade.⁵ Of particular significance for political science has been Douglass North's application of path dependence to institutional analysis.⁶ North argued that institutional development is path-dependent. Established institutions generate powerful inducements that reinforce their stability and further development, while new institutions involve high start-up costs and other obstacles to their emergence.

In political science, the concept of path dependence has been elaborated by the scholars working within the framework of historical institutionalism. Paul Pierson, in particular, clarified the nature of path-dependent political processes as those which trigger feedback mechanisms which, in turn, reinforce the recurrence of a particular pattern into the future. The high 'switching costs' are at the heart of path-dependent political processes. As Skocpol and Pierson explained, "once actors have ventured far down a particular path, they are likely to find it very difficult to reverse course [and] the political alternatives that were once quite plausible may become irretrievably lost."⁷ Several implications flow from the application of the concept of path dependence to political analysis. First, in a path-dependent sequence, early events and choices are far more consequential than the later ones. Secondly, at the early stage of political processes, several alternative outcomes are equally feasible. Thirdly, political outcomes which appear inevitable and logical may result from trivial and unintended choices. Finally, path-dependence entails institutional inertia and inadequacy. After a

⁵ Brian W. Arthur, *Increasing Returns and Path Dependence in the Economy* (Ann Arbor, MI: University of Michigan Press, 1994); Paul Krugman, "History and Industry Location: The Case of the Manufacturing Belt," *American Economic Review* 91 (May 1991): 80-83; Paul M. Romer, "Increasing Returns and Long-Run Growth," *Journal of Political Economy* 94 (October 1986): 1002-1037.

⁶ Douglass C. North, *Institutions, Institutional Change and Economic Performance* (Cambridge, UK: Cambridge University Press, 1990) and "A Transaction Cost Theory of Politics," *Journal of Theoretical Politics* 2 (October 1990): 355-67.

⁷ Theda Skocpol and Paul Pierson, "Historical Institutionalism in Contemporary Political Science" in *Political Science: State of the Discipline*, ed. Ira Katznelson and Helen V. Milner (New York: W.W. Norton, 2002), p. 665.

certain point of development, existing institutional arrangements and policy approaches are likely to persist, as long as the costs of switching course remain high. Thus, present institutions and programs may be both inadequate to current problems and out-of-step with shifting interests.

Jacob Hacker clarified the likelihood of path dependence in the formation of social policy. He argued that possibilities for path-dependence are greater to the extent that the following conditions hold true:

First, a policy creates or encourages the creation of large-scale organizations with substantial set-up costs; second, a policy directly or indirectly benefits sizable organized groups or constituencies; third, a policy embodies long-lived commitments upon which beneficiaries and those around them premise crucial life and organizational decisions; fourth, the institutions and expectation a policy creates are of necessity densely interwoven with broader features of the economic or society, creating interlocking networks of complementary institutions; and fifth, features of the environment within which a policy is formulated and implemented make it harder to recognize or respond to policy outcomes that are unanticipated or undesired.⁸

Hacker found that these conditions hold true for many public policies and institutions. More arrestingly, he argued that *private* welfare provision, and the institutional arrangements surrounding them, may be “more prone to path dependence than public social programs.” Privatized systems of social benefits create “resourceful and mobilized vested interests with strong incentives to monitor and respond to threatening policy developments.” Because they tend to rely on third parties, privatized approaches typically garner support not just among their beneficiaries but also among private organizations that subsidize or deliver benefits. Moreover, reduced “visibility, traceability, and political control” of privatized approaches provide additional barriers to change, allowing even costly or undesirable systems to endure

⁸ Jacob S. Hacker, *The Divided Welfare State: The Battle Over Public and Private Social Benefits in the United States* (New York: Cambridge University Press, 2002), p. 55.

over long periods of time. Private systems of social provision are also likely to attract greater support from the business community which exerts a disproportionate influence in the political arena.⁹

Hacker's fundamental conclusion, and the one that received very little attention in the literature on social policy, is that "privatized approaches may be a source of 'policy-feedback' no less powerful than public programs, profoundly shaping politics and policy development."¹⁰ This thesis is particularly relevant to the analysis of American health care politics, dominated as it has been by private institutions and privatized policy approaches. The growing recognition of the hybrid, public/private character of American health care and welfare systems, combined with the fruitful extension of the 'path-dependence' theory to the effects of private programs and institutions, requires that we deepen the analytical agenda. As Hacker noted, "private social provision ... creates policy 'capacity' in the private sector that rivals the capacities of state administrators."¹¹ Thus, it is incumbent on political scientists studying health care politics to look "more closely than analysts usually do at the interests, demands, and structure of the private organizations."¹² Yet, the tendency to view formal political processes and public policies as decisive factors will not be easy to overcome.

In regard to the system of health care provision in the United States, the presumption of the privileged role of government action and public policy is not justified. Until the passage of Medicare/Medicaid programs in 1965, government

⁹ *Ibid.*, pp. 56-57. Hacker noted that, while the effects of path dependence in the private sphere of social provision may be even stronger than in the public sphere, the character of path dependence is likely to be different. Specifically, "because privatized approaches allow much greater discretion on the part of private actors, they are likely to foster a more dynamic sphere of benefits, allowing substantial changes within the confines of existing policy." [*Ibid.*]

¹⁰ *Ibid.*, p. 58.

¹¹ *Ibid.*, p. 284.

¹² *Ibid.*, p. 23.

action and public policies were not in any way primarily responsible for shaping the American health care system. To be sure, state and local governments helped promote private health care provision through subsidies and tax exemptions to hospitals and other institutions. Most other decisions about the organization and practice of medicine, as well as access to and costs of medical services, were largely left in the hands of the medical profession and private initiative. With the exception of the veterans' hospitals, public health care institutions have been decidedly few in number and residual in purpose, treating those classes of patients whom the private institutions refused.

When it comes to American health care, private institutions and policies cannot be studied as a realm that is secondary and complementary to public programs and policy. Such an approach would be in direct contradiction with the preponderance of historical evidence of the predominantly private nature of American health care institutions and the extraordinary extent of private power and leadership in medicine and health care. The unusually large size of private health care in the United States is itself the overarching factor in the 'path-dependence' of American health care politics, characterized by the persistence of largely private systems of health care provision and insurance. Thus, private health care institutions must be approached as fundamental and still predominant forces of health care politics.

In contradistinction to conventional concepts, it is necessary to recognize that private institutions and approaches do not only stem from, or interact with, public policy. Private institutions and their actions are themselves sources and expressions of *policy*. In political science, it is conventional to reserve the term policy to describe the decisions and practices of governments and public agencies. Nevertheless, in regard to those fields of social provision dominated by private institutions, this convention is

of limited usefulness. It overrates the degree of public control and underestimates the significance of private action.

In constructing the notion of ‘privatized policy approaches,’ Hacker suggests but does not complete the full range of policy action that takes place in hybrid, public/private spheres of social provision. In his conceptual framework, the primary distinction is between the ‘public policies of social provision’ and ‘privatized policy approaches.’ The former are understood as government-funded, publicly-administered programs, while the latter mean those programs which are privately provided but are also subsidized by tax exemptions and subsidies. If this distinction is meant to suggest a full range of policy types in the public/private system of social provision, both ends of the range are open to critique. The public end of the range (public policies) does not fully reveal the historical and present significance of private-sector forces and interests in shaping and re-shaping ‘public’ policy. The private end of the range is even more problematic. It seems to suggest that private social provision is always conditioned by the enabling public policies and that there is no such thing as primarily private social provision. In the sphere of health care provision, this conclusion is not warranted by historical evidence. Not only are there many instances of primarily private institutional developments, many public policies must be seen as accommodations of, and adjustments to, the overwhelming private power.¹³

It is necessary to recognize that in the hybrid, private/public systems of social provision, private institutions and organizations are policy-makers in their own right. This is not to say that they are autonomous from public actors. On the contrary, this approach would recognize the mutual constraints that both public and private institutions impose on each other. Most of the time, private policy-making is

¹³ There are many examples of this but FDR’s decision to exclude health care insurance from the New Deal agenda may be paradigmatic.

constrained both by public forces and by competing private interests. When conducted at the level of separate institutions, private policies would be characterized by the dynamics of diffusion and influence quite different from those of public policies. They will be more similar to those processes of technological and institutional path dependence that have been ascribed to economic processes and institutions, because private health care institutions are decentralized to a much greater extent than government institutions and programs.

Academic Medical Centers and the American Health Care System

The research presented in this dissertation provides evidence that academic medical centers, as well as private health care institutions more generally, make policies and shape health care politics. One qualification needs to be made before summarizing my findings. The ability of any one institution, or even one sector of economy and society, to shape the political environment is necessarily limited. This, however, is also true of all levels of government: local, state and even federal. In and of itself, the existence of constraints is not a disqualification from the political realm and policy-making capacity. What is decisive is whether institutions exercise significant freedom in shaping important areas of their functioning and development and if some of their crucial decisions become either path- or pattern-setting. In this sense, academic medical centers, both singly and jointly, have had a great influence on the making of the American health care system.

Academic medical centers have been practically and symbolically central to modern American health care. Emerging during the early decades of the twentieth-century, academic medical centers embodied the aspirations of both professional and social elites involved with medicine and health care. As massive agglomerations of financial, technological, and human resources, as well as exclusive sites of professional training and clinical research, academic medical centers exercised

enormous structuring influence on the entire medical and health care field. The first institution of its kind in the nation, Columbia-Presbyterian Medical Center was centrally involved in some of the crucial struggles which shaped American academic medicine. Its institutional practices and policies influenced the entire field of its sister institutions, as well as a broader sphere of American medicine and health care.

The first ‘path-setting’ struggle took place when the Columbia-Presbyterian Medical Center was just being created.¹⁴ At issue was whether all of the medical school faculty – including those in clinical departments – should be required to hold ‘full-time’ appointments. Such ‘full-time’ appointments would mean that the faculty members would have to devote all of their time to research, teaching, and professional services in the teaching hospitals and forego their often lucrative private practice. One of the pivotal episodes in the struggle over the ‘full-time’ requirement took place at Columbia-Presbyterian between 1910 and 1925. So serious was the conflict that it nearly derailed the building of the nation’s first Medical Center. Although nominally confined to medical schools and their affiliated hospitals, the outcome of this struggle had profound consequences for the overall organization of health care provision in America. At stake was the class and organizational character of academic medicine. In the larger scheme of things, the full-time requirement was part of an attempt to restructure American medicine from a ‘small-business’ to ‘corporate’ model and to make more physicians ‘employees’ rather than ‘independent entrepreneurs.’

The ‘full-time’ struggle presents a perfect example where ‘path-setting’ policy is negotiated entirely in the private sector by private actors. The conflict pitted the elite medical schools against two powerful philanthropic foundations. Like the larger process of the modernization of American medicine, this struggle unfolded as a

¹⁴ This episode is the subject of Chapter 3.

predominantly private-sector affair. Both the foundations and the professional elite did not favor governmental involvement and the governments did not get involved. The resulting policy, however, had an enormous and path-setting impact on both private and public medical schools and on the field of health care provision at large.

Ever since the 1920s, when academic physicians fought to preserve their stake in private practice, medical centers were compelled to expand their involvement in providing care for private patients, both to allow their faculty members to enjoy higher incomes and to use a part of the profits to support institutional purposes. In the 1980s and 1990s, when the medical centers' hypertrophied clinical services were occupying more and more of their human and financial resources, while giving little back to education and research, the ultimate price of that fateful choice was becoming apparent. With a slowed growth of federal support, the maintenance of the enormous research capacities, built up after the war, required new methods of financing. In a radical break with traditional tenets of academic ethics, medical centers and individual investigators began to accept corporate sponsorship in exchange for patent rights to their intellectual work and to form their own for-profit biomedical research companies. Although, through these and other methods, the medical centers stayed afloat, all three elements of their original mission – charitable care, medical education, and scientific research – may have suffered permanent damage through their ruthless exposure to the strictures of the market.

The actual construction of the Medical Center, as well as the first two decades of its institutional development, presents more evidence that the choices of private organizations can have profound policy consequences.¹⁵ Providing adequate treatment and insurance for low- and middle-income Americans have been persistent challenges

¹⁵ This period is investigated in Chapter 4.

of our health care system. These failings are typically understood to stem from the highly privatized and commercialized nature of American system of health care provision but a closer look reveals more precise mechanisms of their institutional structuring of these issues. However, the inadequacy of the outpatient services for low-income patients and the inpatient services for the middle-income patients were importantly structured by the institutional choices. Who was typically appointed to serve these patient groups, how appointments were structured and compensated, and whether they held research and career-building potential were all important factors structuring the quality and availability of these services. Disparities in health care access were not simply reflections of the differential social status of different patient groups: they were also linked with specific institutional arrangements of academic medicine. The two structures interacted: unequal patients created unequal doctors and unequal doctors created unequal citizens. This process was partially clear to some actors within academic medicine and the way institutions reacted to these problems created lasting patterns of health care provision.

The patterns of health care provision in academic medicine were created in both internal and external relationships which the Columbia-Presbyterian Medical Center forged during this era. During the first two decades of its existence, the Center added several specialized hospitals to its site, while affiliating with a dozen other regional institutions. Its relationship with public institutions was especially noteworthy in its reinforcement of the long-lasting public/private division of labor in American medicine. Class, race, and immigration were fundamental social issues shaping health care provision during this period. Their specific expression was mediated and particularized by the intervening structures of institutional power and professional interests. Both patient and provider positions must be understood as

‘institutional class positions,’ stemming from complex interaction and intersection of class, race, immigration, occupational and organizational factors.

Who staffs the various positions in the occupational and organizational terrain of health care provision is an important determinant of both health care disparities and even social structure more generally. Until the 1960s, governments were not actively involved in structuring the composition of medicine and other health professions. The issue was decided largely at the level of medical institutions, the medical profession, and the forces of civil society which fought to defeat or uphold inequality and discrimination in medical school admissions and in the medical profession more generally.¹⁶ Academic medical centers played an active role in constructing a system of medical training and practice that was simultaneously divided by class, gender, race, and ethno-religious identity. Different, yet intersecting methods of discrimination were practiced against women, African-Americans, and Jewish and Catholic applicants. In regard to different groups, exclusion was accomplished at different points in the progression toward the medical profession, at different institutional locations, and by different mechanisms. Even when nominally included, the marginalized groups were relegated to the ‘institutional class of their own.’ Even after the decisive entrance of the federal government into the battle against discrimination, academic medical centers continued to shape the ease or difficulty with which the marginalized groups could enter particular schools, medical specialties, and the profession as a whole.

While the decade of the 1960s greatly increased the role of the government in structuring and regulating the health care system, private institutions remained powerful actors as well. The struggle to unionize health care workers testified to the

¹⁶ For a detailed discussion of these processes, see Chapter 5.

continued power of private health care organizations. During the 1960s and early 1970s, New York City was the epicenter of a drive to unionize non-professional health care workers, a political struggle with far-reaching consequences for the nonprofit sector as a whole. Although the conflict prompted a series of governmental interventions, the crucial battles took place at the level of individual institutions and their organized opponents. As a result, the structure and politics of particular institutions played a significant role in shaping the course and outcome of the struggle. The decisive cleavages were not prefigured in the organizational and social structure of the medical centers, but were constructed in the process of struggle by the rhetorical and practical strategies of the rival organizations.¹⁷

The policy-making (and breaking) capacity of private organizations was underscored in another important development during this period. Between the early 1960s and the mid-1970s a cluster of issues under the rubric of ‘community health planning’ dominated both public policy and private efforts to solve a health care crisis in the lower-class, minority neighborhoods. While the federal government sought to encourage community solutions to growing health care crisis, the fate of this policy initiative was decided at the level of specific institutions and regional health care systems. Like the larger movement, Columbia’s community health planning initiative was both short-lived and largely unsuccessful. The fragmented, hierarchical, and insular structure of the Medical Center was largely responsible for the initiative’s failure. Institutional marginality of primary medicine, public health, and public hospitals in American health care handicapped the initiative from the start, determining the way in which the initiative was eventually assimilated. Competition for leadership and participation marred the planning of the initiative, reinforcing

¹⁷ For more on this episode of intra-organizational politics, see Chapter 6.

already powerful incentives driving individual advancement and institutional conformity.

Dynamics of Politics and Policy-Making in Academic Medicine

The simple formulation of my first contention – that medical centers make health care policy – is actually misleading because the policies medical centers make are themselves articulated in the process of conflict and struggle. Medical centers are not mini-leviathans; rather, they are *sites* where influential actors are located, important interests are articulated, significant conflicts unfold, and far-reaching settlements emerge. Like most organizations, medical centers are headed by powerful elites, yet they do not act monolithically. Their politics and policies are accompanied by conflict and contestation and the outcomes of internal struggles cannot be assumed as given. As institutional *sites*, rather than closed organisms, medical centers are permeated by varied co-presence and influence of other organizations and institutional forces. It is this complexity which makes their politics less predictable than is commonly held. It also allows a possibility of institutional change with significant political implications.

The conceptual framework developed to understand the politics of the academic medical builds on two theoretical approaches: the neo-Durkheimian theory of micro-classes and the theory of intersectionality. Proposed by David Grusky and his collaborators, the neo-Durkheimian approach calls for greater attention to the micro-level of social organization and stratification. In this view, “the labor market is indeed organized into classes, albeit in a more detailed level than is conventionally allowed.”¹⁸ To capture these structuring effects, Grusky and his collaborators propose

¹⁸ David B. Grusky in collaboration with Gabriela Galescu, “Foundations of a Neo-Durkheimian Class Analysis” in *Approaches to Class Analysis*, ed. Erik Olin Wright (Cambridge, UK: Cambridge University Press, 2005), p. 51.

to disaggregate conventional ‘large-class’ categories and to focus on the occupations and occupational associations which actually exhibit many characteristics typically ascribed to classes. The principle advantage of a disaggregate approach is a greater realism of the resulting ‘micro-classes.’ Occupations are deeply embedded in our economic, legal, educational and demographic institutions, while conventional aggregate classes lack comparable institutional grounding and thus remain rather abstract and theoretical concepts.

The call for disaggregation is particularly valuable for the analysis of intra-organizational politics in that it enables us to apply the fundamental socio-political categories at the micro-level. However, an exclusive focus on occupations as ‘micro-classes’ is inadequate for understanding the politics of academic medical centers and other similar organizations. Both particular occupations and the larger system of occupations are significantly structured and divided by multiple dimensions of difference, including race, gender, class, as well as by the organizational structures of employment, and education. While several areas of scholarship attempted to relate multiple dimensions of organizational structure, the most systematic articulation of multi-dimensional approach has been offered by the theory of intersectionality. Its central contention is that social structure must be viewed as a multidimensional and varied terrain shaped by race, class, gender, sexuality, nationality, religion and other systems of social division. Each of these structuring principles is partly autonomous, yet also intertwined with and complicated by others. The manner and degree to which each dimension of difference shapes concrete social positions varies within historical, cultural, and institutional contexts. It is these context-bound intersecting systems that account for the growing complexity of social structure and political processes.

Five dimensions of inequality were singled out as central to the analysis of the structure and politics of academic medical centers: social class, gender, race,

occupational divisions, and organizational hierarchies. Far from a complete set of differences structuring the many areas of academic medicine, these are the most frequent and general elements at play. Other and related concepts, such as ethno-religious identity, citizenship, immigrant status, and career, were added as necessary to analyze specific cases. The term ‘institutional class positions’ was proposed to denote those varied and contingent positions that emerge at the intersection of the five structuring dimensions.

My research confirmed that the politics and policies of the academic medical centers have been importantly structured by the varied intersections of the five major dimensions of institutional structure. Table 8.1 summarizes rates the salience of the five dimensions of difference in each of the five cases I studied. All dimensions were found to be highly or moderately salient in three or more cases of intra-organizational politics investigated in this study. Moreover, the measure of *immediate* salience does not reveal the full significance of race, gender, and class. For instance, race and gender were not *immediately* salient in the conflict over the ‘full-time requirement’ only because women and minorities were already excluded from faculty positions at the elite medical schools. Thus, in its immediate content, the conflict did not focus on issues of race and gender.¹⁹ Similarly, the low *immediate* relevance of class to the structure of medical school admissions resulted from the wholesale exclusion of the lower-class applicants accomplished by the modernization of the American medical education, as well as from the close intertwining of class with race and ethno-religious identity. Where particular institutions are able to exclude the entire groups, the

¹⁹ In the chapter dealing with the ‘full-time’ conflict I suggest that the strategies employed in the struggle had specific ideological content, consistent with several theories of the professions and the middle class. Whether the ideological and rhetorical devices involved subtle ‘gendered’ and ‘racialized’ might be an interesting question for a broader inquiry into this issue.

salience of the categories of exclusion must be sought in a broader or different institutional terrain.

Table 8.1. *Immediate Salience of Class, Race, Gender, Occupational Division, and Organizational Hierarchy in Five Cases of Intra-Organizational Politics and Policy-Making*

Chapter	3	4	5	6	7
Case Description	The conflict over the proposed restructuring of all medical faculty appointments on a full-time basis without private practice	Conflicts over patient services segregation, specialty mix, public/private division of labor and community obligations	Admission of women and minorities to medical school, post-graduate study, and institutional appointments	The struggle for the unionization of the various groups of workers employed by the medical school and its clinical affiliates	Institutional conflict over the proper response to the urban health care crisis and the community health planning initiative
Period	1910-1926	1922-1945	1891-1980	1958-1976	1970-1976
Class	***	***	*	***	***
Race		**	***	***	***
Gender		**	***	***	
Occupation	**	***	***	***	***
Organization	***	***	***	***	***

Notes: *** = highly salient, ** = moderately salient, * = somewhat salient

My analysis allows me to articulate two contributions to the theories of intersectionality and micro-class analysis. The first concerns the process of *refraction* within the intersectional structure and the second highlights the phenomenon of *institutional cross-cutting* in the structuration of institutional micro-classes.

That the intersection of two or more dimensions of difference can change the character of one or both of them has been a foundational insight in the study of intersectionality. Focused on the juncture of race and gender, early proponents of intersectionality pointed out that gender is racialized and race is gendered for the bearers of multiple oppressions. This mutual alteration is akin to refraction, when one line of division is refracted after its intersection with another line. Race and gender are powerful and fundamental dimensions of social structure and their capacity to refract any number of social divisions is not in doubt. In my research, however, I have found that even occupational divisions and organizational hierarchies may also be capable of refraction.

In the struggle to unionize the workers at Columbia-Presbyterian, gender was refracted by occupational, organizational, and class dimensions. At Presbyterian Hospital, an all-female social work department was at the forefront of a protracted struggle for unionization, but a predominantly female clerical unit at P&S had the highest percentage voting against representation by any collective bargaining organization. In both institutions, women in technical and service positions were as likely to be actively involved in organizing and union activities as men, whereas at the professional level only one and predominantly female occupational category was mobilized into the struggle. Although both social work and nursing could be classified as ‘feminized semi-professions,’ their members acted very differently in regard to unionization. The explanation for this difference lies in the refracting effects of organizational and occupational positions. Some of these roles, such as secretarial and clerical positions integrated female workers into organizational structures, albeit on highly subordinated and personalized terms reminiscent of gender relations in the patriarchal family. Other careers, such as social work, segregated women from men in the lower-paid, less prestigious occupational categories with an unsure claim to

professionalism and its attendant perks. Still other jobs at both hospitals and medical schools preyed on the low social status of minority and immigrant women, exploiting the dual basis of that status. These different, yet distinctly feminized class locations placed their occupants in different relationships to their superiors and employers, affecting unsurprising differences in their ability and inclination to defy organizational power in their workplace.

The difference between social work and nursing, for example, had to do with very different degree of incorporation into academic medicine and subordination to the Center's professional and administrative leaders. Within medicine, social work was both insignificant in size and marginal in function. Thus, the ties of inclusion and subordination linking social work with the medical center were rather weak. The situation of nursing was much the opposite. It has been a crucial part of the hospitals and its subordination was firmly established. Yet, another crucial difference lay outside of the Medical Center and had to do with nursing's and social work's respective occupational associations. Social work could probably count on and actually received support for its occupational association. In contrast, nursing associations remained extremely cautious in regard to the unionization question.

In each of the positions that emerged during unionization struggle, gender was a crucial structuring factor, yet its actual expression in the unionization struggle was refracted by the intersection with occupational factors (such as support of the occupational association) and organizational position (such as degree and character of work subordination)

Another example of refractory influence of occupational and organizational structures is the so-called 'semi-private' patient problem investigated in Chapter 4. While it is expected that the availability and quality of health care would vary with the social class of the patient, the direct and linear relationship is broken by the

peculiarities of institutional arrangements. During the period I investigated, this was the case for middle-income patients who needed hospitalization; today, this phenomenon is observed in the unavailability of health insurance to the working poor who find themselves in the gap between private, employer-sponsored insurance and Medicaid. Unwilling to go to the free wards and unable to pay for private rooms, the 'semi-private' patients arguably faced the highest barriers within the system of class-differentiated hospital care. The reason for this refraction of the expected influence of class lies in organizational and occupational structure of academic medicine. Unlike private practitioners, who were always more interested in higher class patients, academic physicians interested in two groups of patients: the very wealthy for their private practice and the ward patients for their research and teaching purposes. Middle-income patients into this gap and were of interest only the young academic faculty who hoped to build lucrative private practices but had to start with such a middling clientele. Outside of the medical center, concerns of the middle-income patients were beginning to be heard by both governments and fledgling insurance companies. Young professionals, however, are in perpetually weak situation vis-à-vis their employing organizations, while the influence of both governments and insurance companies over the structure of health care provision was still very weak at the time. Thus, both internal and external institutional factors refracted the influence of class on health care access and quality.

Along with refraction, the notion of institutional cross-cutting emerges as an important theoretical contribution of my research. Both vertical and horizontal forms of organization have been shown to be prominent in modern societies. The vertical entities, exemplified by capitalist firms and bureaucratic organizations, are said to be the "communities of unequals," combining members of different classes and social statuses. The horizontal bodies, such as occupational associations, trade unions, or

status groups, unite individuals occupying same or similar socio-economic positions. Within the scholarship on social stratification, there have been many tendencies to privilege either vertical or horizontal organization and to deemphasize the importance of the other one. Class theorists, for example, highlighted the historical significance of the horizontal organizations. Non-class theories often emphasized the robustness of the vertical structures instead.²⁰ The neo-Durkheimian micro-class theory is no exception in this regard. It proposes to conceptualize classes as occupational associations, emphasizing their homogeneity as horizontal forms of social and economic organization.

My research does not support privileging either horizontal or vertical forms of organization. Instead, it calls for attention to widespread institutional cross-cutting so evident in the structure and politics of academic medicine. While ostensibly studying a single institution, what I often discovered was the palpable presence – to the point of intrusion – of other institutions into the organizational space of the medical center. Sometimes, other institutions made their presence felt through multiple memberships of the staff, for instance, in professional associations. At other times, external institutions attempted to incorporate the center's staff into their ranks, most notably labor unions. Finally, some institutions – particularly foundations, government, and pharmaceutical companies – made their presence felt through funding or legal-political authority. The overlapping, multiple organizational fields is what I call institutional cross-cutting. If academic medicine can be imagined as a series of relatively standardized vertical organizations (the academic medical centers), other organizations – such as professional societies, labor unions, or financing and regulatory entities – cut across the institutions of academic medicine and, in the

²⁰ See, for instance, a discussion in Erik Olin Wright, "Class and Occupation," *Theory and Society* 9, no. 1 (1980).

process, carve out their own institutional presence within the sector. One of the implications of institutional cross-cutting is that the cells which emerge at the intersections of primary and secondary institutions are some of the most visible and influential in political struggle. This is not surprising, since this is where we would find competition between institutionalized, organized opponents. Another inference, however, is that as-yet unorganized cross-cutting layers can become organized and that important changes can be expected from the process of such cross-institutional organization.²¹

Looking to the Past to Understand the Present

The theme of the Presbyterian Hospital's 1995 Annual Report was 'metamorphosis.' Only two years prior, the Hospital had come perilously close to extinction, posting a \$22.5 million deficit and prompting industry watchers to predict its demise in the era of managed care. But the dour predictions proved wrong. In 1995, Presbyterian finished with a nearly balanced budget, increased the number of discharges, reduced the average length of stay, and boasted a high occupancy rate. Still, tremendous challenges lay ahead, brought on by an erosion of support for academic medicine and "a Darwinian race toward market-driven health care." While no longer facing extinction, the Hospital had to undergo a transformation – a metamorphosis – in order to survive.²²

²¹ For example, a pioneering struggle for unionization launched by the Presbyterian's Department of Social Work, which I detail in Chapter 6, illustrates this phenomenon of institutional crosscutting. While this path-breaking drive of a small, all-female department was undoubtedly rooted in a specific occupational, gender, and class identity of the group, the protracted battle came to involve a host of cross-cutting institutions, most notably the National Association of Social Workers and the New York State Labor Relations Board. Interestingly, the social workers did not succeed until a much larger, non-professional segment of the Hospital's labor force won union recognition, highlighting another facet of cross-cutting institutional influence. In contrast, the nurses' professional associations had a cooling effect on their unionization drives at CPMC and elsewhere. In general, the example of related occupational enclaves, situated at other institutions, had a significant effect on the dynamic of the unionization struggle.

²² Presbyterian Hospital in the City of New York, Annual Report, 1995.

The report argued that Presbyterian was in the midst of the most radical transformation in its history, surpassing even its historic alliance with Columbia University College of Physicians and Surgeons in 1911, a union that created the nation's first medical center. The transformation required serious changes to the hospital's institutional model. As the lead article starkly noted, "[t]he days of the stand-alone teaching hospital, focused exclusively on research, education, and patient care, are over." Located in the poorer section of Manhattan, an independent teaching hospital was not financially viable in the era of tightening budgets and growing competition among providers. Controlling costs, modernizing billing and ordering systems, establishing clinical branches in higher-income parts of the city, and increasing clinical revenues from the hospital affiliated physicians were all part of the survival strategy. The central piece of the plan, however, was creating a regional network of providers that could offer a "marketable insurance product."²³

The formation of this alliance was in its early stages in 1995, but the goal was to bring in 25 to 30 affiliated institutions within a few years, including specialized and community hospitals, outpatient facilities, physician networks, long-term-care facilities, home-care agencies, and freestanding diagnostic sites. The aim was to create a regional integrated health-care network, providing "a continuum of care from checkups and vaccinations to hip replacements and health transplants." To be competitive, the network had to combine high quality, low cost and wide geographical distribution. Ultimately, the objective was to be able to say to any employer in the metropolitan area that the network had a hospital or a physician within ten minutes of every one of its employees. To contain costs, the new entity had to deliver as much care as possible in the lower-cost facilities, limiting the use of expensive, specialized

²³ *Ibid.*

hospitals to procedures which could not be performed anywhere else. A patient needing a heart transplant, for example, would receive preoperative care and testing in the community hospital near her home, and then would enter Presbyterian to undergo the transplant. Once stabilized, she would return to the local hospital for postoperative period and rehabilitation. By creating its own comprehensive network, Presbyterian was hoping to recapture some of the clinical revenue being lost to increased competition and lower reimbursements. It was hoped that the ‘profits’ of this novel venture would go towards subsidizing graduate medical education, clinical research, and care of the uninsured. In the cost-conscious era of the managed care and the dwindling state support, this was seen as the only way to maintain the hospital’s historic academic and philanthropic missions.²⁴

Only three years later, on January 11, 1998, another momentous transformation took place. The teaching hospitals of Columbia and Cornell merged to form one of the most comprehensive university hospitals in the world, the NewYork-Presbyterian Hospital. Affiliated with two Ivy League medical institutions, Columbia University College of Physicians & Surgeons and Weill Medical College of Cornell University, the new hospital became a part of not one, but two academic medical centers. Besides capturing top ranks in surveys of the nation’s hospitals and physicians, the new entity continued to develop a network of integrated regional health care services. Named the NewYork-Presbyterian Healthcare System, this federation of renowned hospitals, specialty institutes, and continuing care centers in New York, New Jersey, and Connecticut delivers a wide range of medical services to the tri-state community.²⁵ By 2005, the network had grown to include 51 institutional members, including 30 acute

²⁴ *Ibid.*

²⁵ Information about the NewYork-Presbyterian Healthcare System is available online at www.nypsystem.org.

care hospitals, 14 continuing care facilities, and several ambulatory and specialty care facilities.²⁶

What is remarkable about the tremendous changes which Presbyterian had undergone in the 1990s is how singularly they were focused on health care services. Neither the needs of research, nor the goals of medical education were central to the series of affiliations and mergers that had transformed Columbia's teaching hospital. Although the stated goal was to preserve the institution's historic mission of research, education, and charity care, the entire focus of reform was to create a new, radically expanded package of clinical services. Research, of course, was not being abandoned. The year of the New York and Presbyterian merger was the first of five-year doubling of the National Institutes of Health medical research budget and Columbia saw a sixteen percent increase in its NIH grants. But research was now much more squarely a province of the medical school, while the hospital's attention was on health care services. There were also notable changes in how the mission of scientific research was carried out. The very first achievement mentioned in the medical school's 1999 annual report was that "Columbia University will earn more income in the coming year from its intellectual property than any other university in the country."²⁷

While there continues to be a lively discussion about the wisdom of the strategies of merger and affiliation by the academic medical centers, it is clear that they were undertaken in response to real changes in the overall system of health care provision in the United States.²⁸ In fact, many scholars have not hesitated to

²⁶ *The System Standard: A Publication of NewYork-Presbyterian Healthcare System*, Spring 2005, available online at www.nypsystem.org.

²⁷ Combined 1999 Annual Report of the NewYork-Presbyterian Hospital, Columbia University College of Physicians & Surgeons and Joan and Sanford I. Weill Medical College and Graduate School of Medical Sciences of Cornell University.

²⁸ See, for example, Henry J. Aaron, ed., *The Future of Academic Medical Centers* (Washington, D.C.: Brookings Institution Press, 2001), especially pp. 6-8, 49-72.

pronounce these recent developments in academic medicine and the health care system as a whole to be nothing short of revolutionary. Kenneth Ludmerer argued that at the end of the twentieth century American medical education has entered a second revolutionary period. Among the major characteristics of this period are “the erosion of the clinical learning environment, the diminishing of faculty scholarship, and the reemergence of a proprietary system of medical schools in which the faculties’ financial well-being was placed before education and research.”²⁹ Almost twenty years earlier, Paul Starr had rather presciently predicted a rise of corporate enterprise in health services, resulting in “greater disunity, inequality, and conflict throughout the entire health care system.”³⁰ The corporate transformation has largely been realized in the three decades since the publication of his classic work.

In these accounts, the sense of crisis and change is heightened by the institutional success and stability achieved during academic medicine’s golden age. In Ludmerer’s view, the mid-century medical centers had achieved a remarkable harmony among their three goals – of research, medical education, and patient care – and fulfilled the social contract by earning public trust and capturing public confidence.³¹ For Starr, the development of academic medicine was firmly guided by the near sovereign power which the organized medical profession achieved over its ranks and its field of work.³² Both of these conditions began to unravel during the 1970s. The relationship between research, education, and care became decidedly unbalanced in favor of the last and to the detriment of the first two. Academic medicine was also losing its cultural authority and public goodwill. While still

²⁹ Kenneth M. Ludmerer, *Time to Heal: American Medical Education from the Turn of the Century to the Ear of Managed Care* (New York: Oxford University Press, 1999), pp. 370, 381-382.

³⁰ Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982), p. 421.

³¹ Ludmerer, pp. 21-41.

³² Starr, pp. 3-29.

worried about government control, the autonomy of physicians and hospitals was threatened by another force altogether. Poised to enter a variety of other health care businesses, corporations began to integrate a previously decentralized system of independent providers and to consolidate ownership and control over emerging health care networks.³³ Medical care was once again facing a major transformation in its institutional structure, comparable in its extent to the developments of a century ago.

While not disputing the seriousness of recent changes, the perspective developed in this dissertation perceives more continuity with previous trends. In part, this is because it discerns less balance and harmony in that past than is commonly found. The conflict among the goals of research, education, and care – which most scholars locate in the 1970s – was present at the very founding of the first medical centers. As I discuss in Chapter 3, it was so serious as to threaten the entire enterprise of building the nation's first medical center. The eventual outcome constituted not so much a genuine resolution of conflicting interests as an inevitable compromise reflecting the relative power of the rivals. Institutional integration and corporate rationalization of American medicine are likewise not new, as both were the engines fueling the emergence of the medical centers during the early twentieth century.

The unity and power of the medical profession also appear exaggerated from a perspective that focuses on long-standing conflicts, rather than eventual compromises. While the profession's elites achieved a remarkable coherence in the system of medical education, licensing, and accreditation, struggles among various specialties, between public health and medicine, and between the medical profession and other institutions and occupations in the health care field were notable throughout the century.³⁴ The effect of professional unity was also aided by the more standardized

³³ Starr, p. 428.

³⁴ See, for example, Chapters 6 and 7.

and hierarchical education and career paths, which powerfully subordinated the younger and less successful members of the profession and marginalized women, minorities and lower-class applicants.³⁵

The concept of institutional class positions is an effective antidote to myths of coherence and unity prone to grow around successful organizations and professional groups.³⁶ It recognizes that most institutions are not only collections of disparate groups but are also crosscut by the influence of other institutions. An in-depth study of the politics and history of the Columbia-Presbyterian Medical Center undertaken in this dissertation suggests a limited usefulness of abstractions such as a ‘social contract’ or ‘professional authority.’ This study documents the extent of internal diversity and conflict inconsistent with unitary conceptions of academic medical centers underlying the imagery of ‘professional dominance’ or institutional coherence of the golden age. An image of the academic medical center as a discrete institutional body capable of entering into a ‘contract’ with its underlying society is also contradicted by the porous and externally-invested picture emerging from my work. The very creation of medical centers has been crucially dependent on the leadership of corporate elites, the patronage of private patients, the trust of working class patients, and, after WWII, the massive public investments in research and infrastructure.

To discern greater continuities between current troubles and past decisions is not to underestimate the seriousness of present threats. They are real enough and should be a cause for concern for citizens and policy-makers alike. The causes of the present troubles, however, may not be very different from those which created the open conflicts and half-hearted accommodations of the past. Most importantly, the problems of academic medical centers are not just institutional difficulties but are

³⁵ See Chapter 5.

³⁶ This concept is developed in Chapter 2 and also discussed in Chapter 1, “Introduction.”

intimately linked with the problems of our social, economic and political organization. The dynamics and composition of the medical centers' workforce and patient pools are deeply reflective of the socio-economic stratification created by our economic, social, and health care policies.

The outcomes of the current problems in American academic medicine carry implications that extend far beyond its sphere. Many writers agree that the country's health care system represents a 'prism' of the larger concern about America's position in the world. In Ludmerer's apt assessment, "[t]he underlying problems that led to turbulence in medicine – the earlier acceptance of the myth of unbridled resources and national capacity, the preoccupation with short-term rather than long-term thinking, the emphasis on immediate gratification, the difficulty of retaining purpose and values in a culture that champions greed and material excess, and the dilemma of providing for public goods and human needs through a private market system beholden only to owners and shareholders – were the same problems that jeopardized other aspects of the country's prosperity."³⁷

Over the past century, the United States has built up truly awesome institutions of academic medicine. As concerned citizens, we naturally wish that these vast resources should yield the highest social returns in the framework of optimal international collaboration. In the perspective developed in this dissertation, prescriptions for success differ from those commonly offered. While the institutional leadership within academic medicine is certainly necessary, even more important might be the leadership of an ascending class coalition whose vision of social progress gives medicine a prominent place. Restoring the mythical balance among research, education and patient care is not enough. What is necessary is a reduction of class-

³⁷ Ludmerer, p. 398.

institutional differences within academic medicine and medical profession as a whole which is, in turn, dependent on reducing class inequality in access to, and the ability to pay for, health care. Finally, the tendency of our system to favor and reward short-term over long-term success must be addressed. Providing longer, healthier and freer lives to all will be a key moment of the process.

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